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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide written grievance summaries for 2 out of 2 residents reviewed (Resident #10 and #62). Findings included: Review of facility policy dated 10/15/24 titled Center Operations Policies and Procedures Grievance/Concern read in part: The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process including receiving and tracking grievances through their conclusion, issuing written grievance decision to the resident with a date the written resolution was issued with the purpose to assure prompt receipt and resolution of resident and representative grievance/concern. 1. Resident #10 was admitted to the facility on [DATE]. The Minimum Data Set quarterly assessment dated [DATE] revealed resident #10 was severely cognitively impaired. A review of the facility's grievance log since 11/21/24 revealed a grievance dated 03/31/25 for Resident #10 by the Responsible Party (RP) regarding a concern that Resident #10 had an appointment and the RP stated his nails were very long and needed trimming. The action taken to investigate the grievance was that the Director of Nursing checked residents' nails, Nurse Aide clipped his nails and shaved his face with a recommended correction action to include providing nail care and rounds to inspect nail care needs. The resolution of the grievance under Written notification provided on (insert date) was noted to be blank. The Administrator signed the grievance. An undated grievance written by the Responsible Party was reviewed for Resident #10. The grievance/concern was that Resident #10 had an appointment and was sent to the appointment without being dressed properly. The recommended correction action was education provided to all staff during an all staff meeting by the Director of Nursing. The resolution of the grievance under Written notification provided on (insert date) was noted to have a date of 07/01/25. On the bottom page of the grievance read, Additional methods that may have been used to discuss resolution with the resident/representative, was checked written. The attached written summary was dated 07/01/25, however it did not correspond to the concern regarding being sent to appointment without being dressed properly. The grievance was signed by the Administrator. (continued on next page)

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

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

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 09/30/25 at 2:10 PM revealed she should have sent a written response to the Responsible Party regarding both concerns. She stated the letter dated 07/01/25 was a written response to a grievance that was filed on 07/01/25 and did not relate to the concern of being sent to appointment without being dressed properly. 2. Resident #62 was admitted to the facility on [DATE]. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #62 was severely cognitively impaired. A review of the facility's grievance log revealed a grievance from Resident #62 for needing help transferring to bathroom. On the bottom page of the grievance dated 05/27/25 read, Date written notification provided, was left blank. Also, on the bottom page of the grievance read, Additional methods that may have been used to discuss resolution with the resident/representative, was checked Face to face. The grievance/concern form reviewed had no back page summary or findings/recommended corrective action(s) filled out. An interview was conducted on 10/01/25 at 10:30 AM with the Director of Nursing (DON). The DON stated she did not know the resident/representative needed to receive a written summary of their grievance resolutions. The DON acknowledged Resident #62 should have been provided with a written resolution and summary. An interview was conducted on 10/01/25 at 10:40 AM with the Administrator. The Administrator confirmed Resident #62 did not receive a written grievance summary of the resolution. An interview on 10/02/25 at 8:17 AM with the Social Worker (SW) revealed that she did not know until today that she needed to provide a written grievance summary to the resident or representative who filed the concern. The SW stated she thought the verbal summary was okay. The SW stated before today, she had only called or verbally spoken to the complainant in person and verbally summarized the grievance, with nothing given to them in writing. The SW added, now she knows to provide a written grievance summary to complainants.

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with residents and staff, the facility failed to protect a resident's right to be free from neglect when two nurse aides (NA) on the 3:00 PM to 11:00 PM shift refused a dependent resident's (Resident #21) requests for transferring her to bed and incontinence care. Resident #21 was left sitting up in her electric wheelchair in her room that had a strong odor resembling bowel incontinence. When Resident #21's incontinence care was provided her brief was heavily soiled with a bowel movement that was caked and dried on her skin. Resident #21 was in a semi-private room, and she stated she was embarrassed and humiliated in front of her roommate by the NAs refusal of care. The deficient practice occurred for 1 of 4 residents reviewed for neglect. Findings included:Resident #21 was admitted to the facility on [DATE] with diagnoses to include hemiplegia affecting left side, cerebral infarction (stroke), and anxiety disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact with no rejection of care behaviors in the lookback period. Resident #21's range of motion was impaired on both sides of the upper and lower extremities, she was always incontinent of bladder and bowel, and dependent on staff for transfers and toileting hygiene.The care plan revised 7/24/25 revealed Resident #21 had a self-care deficit in performing activities of daily living (ADL) related to a stroke with hemiplegia and hemiparesis. The care plan interventions included Resident #21 was dependent on the assistance of two staff members with mechanical lift for all transfers. An interview with Resident #21 occurred on 9/30/25 at 2:50 PM. Resident #21 reported she had a terrible night last night. She stated that she was a smoker and that she usually gets ready for bed after she goes outside for the last supervised smoke break scheduled at 8:30 PM. Resident #21 indicated that she had turned on her call light after her tv show was over at 9:30 PM to request assistance getting ready for bed and that she needed incontinence care for her soiled brief. She stated the two NA's (NA #4 and NA#5) on the 3:00 PM to 11:00 PM shift had refused to provide care to her. She further stated that she had to wait until after 12:30 AM to finally get changed and to go to bed. Resident #21 explained the NAs had refused to provide care for her because she had said a curse word when they turned off her air conditioner. She stated the NAs turned around with the mechanical lift and said they were not going to provide care for anyone who was cursing them and being disrespectful to them. Resident #21 stated she was left in her electric wheelchair in her room facing the tv. Resident #21 indicated that she was in a semi-private room and that the NAs had embarrassed her and humiliated her in front of her roommate, by treating her like a child. She stated that the incident had made her sad and mad at the same time. The Administrator was immediately notified on 9/30/25 at 3:30 PM of Resident #21's allegation of neglect involving NA #4 and NA#5. The Administrator stated she was immediately suspending NA #4 and NA #5 pending the investigation and she was filing a report with the state agency.An interview with NA #5 was completed on 9/30/25 at 4:30 PM. NA #5 stated that she had been the NA assigned to care for Resident #21 last night. She further stated that at around 10:30 PM Resident #21 had requested to be assisted to bed and incontinence care be provided. NA #5 indicated that she asked NA #4 to help her with the mechanical lift to transfer Resident #21 to bed. She stated that when they came into the room with the mechanical lift the temperature in the room was cold, so they asked Resident #21 if they could turn off the air conditioner, and she told them no. NA #5 indicated she turned the air conditioner off anyway and Resident #21 had said a curse word and told them to turn the air conditioner back on. She stated that when Resident #21 cursed at them, she and NA #4 decided to leave the room, because they didn't want to argue with her. NA #5 further stated that she felt like she was disrespected by Resident #21 and that is why she had refused to provide her care. She indicated they left the room and reported the incident to the nurse. NA #5 stated that she and NA #4 left the facility at 11:00 PM without providing care for Resident #21. NA #5 further stated she had been a NA for approximately 1 year and that she had received training on abuse/neglect. An interview with NA #4 occurred on 9/30/25 at 4:45 PM with NA #5 present. NA #4 stated that she was asked by NA #5 to help her assist Resident #21 to bed at approximately 10:30 PM last night. She further stated that she was only there to assist NA #5 and that she was just trying to help. NA #4 indicated that she was not the NA assigned to care for Resident #21. She stated when they entered the room to provide care for Resident #21 it was cold and they had asked her if they could turn off the air conditioner and she had stated, no. NA #4 indicated that NA #5 had turned the air conditioner off and that the resident had said a curse word. She stated she didn't have to put up with anybody talking to her like that 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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, Physician and Consulting Pharmacist interviews, the facility administered an expired medication that was stored in the medication cart to Resident #10 via enteral tube feeding for 9 days for a total of 18 doses. Resident #10 was sent to the Emergency Department and had no adverse outcome as a result of receiving this expired medication. Findings included:Resident # 10 was admitted to the facility on [DATE]. Diagnoses included stroke with aphasia (a language disorder that affects a person's ability to communicate), gastrostomy (tube feed) and gastroenteric reflux disease (GERD). Review of a physician's order written on 12/27/24 for Pantoprazole Sodium Oral (also known as Protonix) Suspension 4 milligrams/milliliter. Give 10 milliliters enterally (via tube feed) two times a day for GERD. The Minimum Data Set admission assessment dated [DATE] revealed Resident #10 was coded as severely impaired and was coded as having a feeding tube. A hospital emergency department note dated 01/19/25 revealed, in part, per nursing facility staff, resident was given his daily dose of Protonix this morning and it was noted after administering that the medication had expired 9 days ago (01/10/25). Resident was currently resting comfortably, nonverbal but able to answer questions by nodding or shaking his head and had no acute complaints. Resident's Responsible Party requested that resident be sent to the emergency department to make sure resident was okay after receiving the expired medication. The hospital course indicated the only side effect from this expired medication would be that it may not be as effective as usual. Resident was discharged back to the facility. Review of the January Medication Administration Record revealed Resident #10 received the Protonix medication twice daily from 01/11/25 through 01/19/25 to include a total of 18 doses. Review of a grievance concern form dated 07/01/25 filed by the Responsible Party (RP) revealed Resident#10 received medications that were expired. The investigation was addressed to the Director of Nursing on 07/01/25 and the action taken for this concern was that education was provided to all nursing staff during an all-staff meeting. A written summary was attached and addressed to the RP stating, in part, we are contacting you to notify of the outcome to your concern regarding [Resident #10] receiving an expired medication. [Resident #10] had no adverse effects from the medication being given and 72-hour charting was completed to ensure there were no signs or symptoms of adverse effects. As a facility, we have measures in place to ensure this does not happen again. We have educated the staff and will be conducting medications cart checks for expired medications. Education in-service record dated 07/01/25 revealed the nursing staff were in serviced to ensure expired medications were discarded and not given to residents. The in-service included checking expiration dates on medications and discard any expired medications to avoid the administration of expired medications. Each of the nurses who administered the expired medication signed the in-service sheet. An interview with the Director of Nursing (DON) on 10/02/25 at 3:00 PM revealed she had started working at the facility in March of 2025. She stated on 07/01/25 she was made aware via a grievance from the Responsible Party of Resident #10 that he received expired medications that had occurred in January 2025. She stated she initiated an in-service with each nurse who signed off that they administered the medication from 01/11/25 through 01/19/25 on 07/01/25 and began medication cart audits. The DON stated she did not know what the previous DON did when this error occurred back in January 2025. A phone interview with Consulting Pharmacist #1 on 11/18/25 at 2:36 PM revealed the ordered liquid Protonix had a shortened expiration date because it was a compound (mixed with another medication) medication, so it did not have a long shelf life. Consulting Pharmacist #1 stated nursing staff should be monitoring the expirations on all medications before administration. She stated she was not sure about the adverse effects of receiving the medication, but that the expired medications could have been contaminated due to the short shelf life. An interview with the Physician on 11/17/25 at 1:10 PM revealed there would be no adverse effects from receiving the expired medication, but that nursing staff needed to follow the regulations and ensure there were no expired medications on the medication carts to avoid the administration of expired medications.

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with resident and staff, the facility failed to provide incontinence care to a dependent resident for 1 of 4 residents reviewed for activities of daily living (ADL) care (Resident #21). Findings included:Resident #21 was admitted to the facility on [DATE] with diagnoses to include hemiplegia affecting left side, cerebral infarction (stroke), and anxiety disorder.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact with no rejection of care behaviors in the lookback period. Resident #21 was always incontinent of bladder and bowel, and dependent on staff for transfers and toileting hygiene.The care plan revised 7/24/25 revealed Resident #21 had a self-care deficit in performing ADL related to a stroke with hemiplegia and hemiparesis. The care plan interventions included Resident #21 was dependent on the assistance of two staff members with the mechanical lift for all transfers and to provide incontinence care as needed. An interview with Resident #21 occurred on 9/30/25 at 2:50 PM. Resident #21 reported that two nurse aides (NA) on the 3:00 PM to 11:00 PM shift had refused to transfer her to bed and provide incontinence care for her. She stated that she had turned on her call light around 9:30 PM and requested assistance getting ready for bed and that she needed incontinence care for her soiled brief. Resident #21 indicated that the two NAs (NA #4 and NA #5) had refused to provide care for her, because she had said a curse word when they turned off her air conditioner without her permission. She stated she had to wait until approximately 12:30 AM for the NAs on the 11:00 PM to 7:00 AM shift to transfer her to bed and provide incontinent care. An interview with NA #5 was completed on 9/30/25 at 4:30 PM. NA #5 stated that she had been the NA assigned to care for Resident #21 last night. She further stated that at around 10:30 PM Resident #21 had requested to be assisted to bed and incontinence care be provided. NA #5 indicated that she asked NA #4 to help her with the mechanical lift to transfer Resident #21 to bed. She stated that when they came into the room with the mechanical lift the temperature in the room was cold, so they asked Resident #21 if they could turn off the air conditioner, and she told them no. NA #5 indicated she turned the air conditioner off anyway and Resident #21 had said a curse word and told them to turn the air conditioner back on. She stated that when Resident #21 cursed at them, she and NA #4 decided to leave the room, because they didn't want to argue with her. NA #5 further stated that she felt like she was disrespected by Resident #21 and that is why she refused to provide care for her.An interview with NA #4 occurred on 9/30/25 at 4:45 PM with NA #5 present. NA #4 stated that she was asked by NA #5 to help her assist Resident #21 to bed at approximately 10:30 PM last night. She further stated that she was only there to assist NA #5 and that she was just trying to help. NA #4 indicated that she was not the NA assigned to care for Resident #21. She stated when they entered the room to provide care for Resident #21 it was cold and they had asked her if they could turn off the air conditioner and she had stated, no. NA #4 indicated that NA #5 had turned the air conditioner off and that the resident had said a curse word. She stated she didn't have to put up with anybody talking to her like that and that they had refused to provide care to Resident #21, and they had left the room. An interview was completed with NA #6 on 10/1/25 at 11:16 AM. NA #6 stated she was supposed to be at work at 11:00 PM on 9/29/25 but that she arrived about an hour late. She further stated that when she went to Resident #21's room she was still up in her wheelchair waiting to go to bed. NA #6 stated she and NA #7 transferred Resident #21 to bed at approximately 12:30 AM. She indicated that Resident #21 was incontinent with bowel and it looked like it had been there for a while because it was caked and dried on her skin. NA #6 stated that Resident #21 was usually in bed when she came in at 11:00 M and that was the first time she had to put her to bed on 11:00 PM to 7:00 AM shift. She further stated that Resident #21 informed her that the NA from 3:00 PM to 11:00 PM shift had refused to provide care for her. An interview with Nurse #7 who was working the 7:00 PM to 7:00 AM shift on 9/29/25 occurred on 10/2/25 at 1:29 PM. Nurse #7 stated she recalled the incident with Resident #21 and NA #4 and NA #5 occurred on 9/29/25 at approximately 10:30 PM. She stated the NAs reported to her that Resident #21 had cursed them when they went into her room to transfer her to bed. Nurse #7 further stated that she had told the NA's she would speak to Resident #21 about the incident. She indicated she was unaware that NA #4 and NA #5 were not going to provide Resident #21 care prior to them leaving their shift. Nurse #7 explained that one of the NAs on the 11:00 PM to 7:00 AM shift was late for work on 9/29/25 and Resident #21 was not assisted to bed until around 12:30 AM. She stated that the NA's had not asked her to assist them with transferring Resident #21 to bed or providing incontinence care. Nurse #7 indicated she was unaware that Resident #21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, the Registered Dietician, the Nurse Practitioner and the Physician interviews the facility failed to verify the accuracy of physician ordered weights for a resident (Resident #6) with congestive heart failure. This occurred for 1 of 1 resident (Resident #6) reviewed for quality of care. Based on observations, record review, staff interviews, the Registered Dietician, the Nurse Practitioner and the Physician interviews the facility failed to verify the accuracy of physician ordered weights for a resident (Resident #6) with congestive heart failure. This occurred for 1 of 1 resident reviewed for quality of care. Findings included: Resident #6 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and dementia. A care plan dated 4/9/25 revealed Resident #6 was at nutritional risk related to frequent hospitalizations, multiple chronic disease processes, history of weight gain and fluid retention, cognitive impairment, therapeutic diet order with restrictions, prescribed diuretics (high risk of weight fluctuations), significant weight loss, and history of increased nutrient needs with pressure areas. Interventions included in part: weigh per policy. A physicians order dated 4/5/25 for Resident #6 revealed Furosemide Solution 20 milligrams per milliliter (mg/ml) intramuscularly (IM) one time now for fluid overload. A physician's order dated 4/07/25 for Resident #6 was to obtain weekly weights for four weeks then monthly weights. A physicians order dated 4/11/25 for Resident #6 revealed Furosemide Solution 20 mgs/ml intramuscularly (IM) one time for excessive fluid. A physicians order dated 4/12/25 for Resident #6 revealed Furosemide 40 milligrams (mg) give one tablet as needed for edema. A physicians order dated 4/17/25 for Resident #6 revealed Furosemide 40 milligrams (mg) one time daily for edema. A physician's order dated 4/24/25 for Resident #6 was to obtain weekly weights for four weeks then monthly weights. A physicians order dated 4/29/25 for Resident #6 revealed Furosemide 40 milligrams (mg) one time daily for congestive heart failure (CHF). A nutritional assessment dated [DATE] completed by the Registered Dietician for Resident #6 revealed in part; Resident #6 had a history of weight gain and loss due to edema, recent hospitalization and poor appetite. She received a consistent carbohydrate and No Added Salt (NAS) diet, with regular texture, and thin liquids. Resident #6 eats independently after tray set up. Pressure ulcers noted to (sacrum, heel, coccyx). Pertinent medications included Furosemide (a diuretic used to treat fluid retention) medication. She remained on 1.5 liter fluid restrictions. Weight loss was 15% over 1 month. Nutrition Recommendations: Reorder Med Pass (nutrition supplement) three times a day. Monitor: Weights, labs, skin, and meal intake. A nutritional assessment dated [DATE] completed by the Registered Dietician for Resident #6 revealed in part; history of weight fluctuations 160 - 200 lbs. (intermittent edema and diuretics), history of intermittent poor appetite due to illness and hospitalizations. No new recommendations at this time. Monitor and evaluate weights, labs, skin, and meal intake. The Minimum Data Set (MDS) significant change assessment dated [DATE] revealed Resident #6 was severely cognitively impaired. She had no rejection of care. She had weight gain and received a therapeutic diet. Resident #6 required staff assistance with activities of daily living (ADLs) and supervision with eating. Review of Resident #6's electronic medical record revealed the following weights recorded using the mechanical lift: 4/08/25: weight 205.0 4/16/25: weight 194.0 4/20/25: weight 174.0 5/08/25: weight 172.0 6/20/25: weight 147.6 7/15/25: weight 146.2 8/03/25: weight 146.0 8/06/25: weight 154.4 9/09/25: weight 152.6 During an interview on 10/01/25 at 2:00 PM Unit Manager #1 stated Resident #6's significant weight changes noted in the medical record should have had a re-weigh done within 24 hours and that was not done. Unit Manager #1 stated the nurse aides obtained the ordered weights and then gave the weights to her and she entered the weights into the residents electronic medical record. Unit Manager #1 stated she did not always check the previous weight to identify any significant weight gain or loss which was an error on her part. She stated the facility policy was that with any weight increase or decrease a reweigh should be done at that time for accuracy and she had not been directing staff to do the reweighs. Unit Manager #1 stated she should have asked for Resident #6 to be reweighed for accuracy to determine if Resident #6 had a 10 to 20 pound weight loss to verify accuracy. A phone interview was conducted on 10/01/25 at 9:20 AM with Nurse Practitioner #1 who stated it was her expectation that residents with significant weight changes get reweighed. She stated that a reweigh was to be done on all weight loss or gain greater than 5% within a month, or greater than 10% in six months, so in order to make the necessary treatment recommendations. During an interview on 10/2/25 at 10:00 AM Nurse Aide #10 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the Wound Care Physician's interview, the facility failed to complete initial wound assessments upon admission to include the wound descriptions with measurements and obtain wound care orders upon admission and when the wound vac (vacuum assisted closure (vac), negative pressure wound therapy that uses suction to aid in wound healing) was not available in the facility for a resident admitted with multiple pressure wounds and osteomyelitis (infection of the bone tissue) requiring intravenous and oral antibiotics. This occurred for 1 of 6 residents (Resident #86) reviewed for wound care. Findings included: Resident #86 was admitted to the facility on [DATE] with diagnoses including a Stage IV pressure ulcer of the left ischium (the lower and back portion of the hip bone), Stage IV pressure ulcer on the sacrum, Stage IV pressure ulcer of the right hip, Stage II pressure ulcer on the right buttock, a deep tissue injury of the left heel, osteomyelitis (an infection of the bone tissue) of the vertebra, sacral, coccyx region, and left thigh, and paraplegia (paralysis of the lower extremities). Review of the hospital discharge instructions dated 3/15/25 for Resident #86 revealed to follow up with the wound center. There were no further wound treatment orders listed on the discharge instructions. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Piperacillin Sodium Tazobactam (a broad-spectrum antibiotic used to treat moderate to severe bacterial infections). Use 3.375 grams intravenously every 8 hours for osteomyelitis for 18 days in 100 milliliters 0.9% Sodium Chloride. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Vancomycin (an antibiotic used to treat severe infections) intravenous solution. Use 1 gram intravenously two times a day for osteomyelitis until 04/03/25. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Sulfamethoxazole-Trimethoprim oral antibiotic tablets 800-160 milligrams. Give 1 tablet by mouth one time a day for osteomyelitis. Review of Resident #86's electronic medical record from 3/15/25 through 3/17/25 revealed no documented admission assessment of the wounds and no documented physician orders for wound care until 3/17/25. A progress note dated 3/17/25 at 9:48 PM documented by Unit Manager #1 revealed in part: admission assessment, Resident #86 was alert and oriented to person, place, and time. He was noted with multiple opened wounds to his buttocks, left ischium, right buttocks, left posterior upper thigh and buttock fold, sacral wound, right hip wound, and right heel DTI. The Physician (previous Medical Director) was notified 3/17/25. Treatment orders and intravenous orders were clarified with new orders received. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order with a start date of 3/17/25 for Wound Vac application (vacuum assisted closure (vac), negative pressure wound therapy that uses suction to aid in wound healing). Gently irrigate the wound to the left ischium with normal saline and pat dry. Apply skin prep to peri wound and let dry. Window pane peri wound with clear wound vac drape. Apply black foam to the wound bed and cover with vac drape then apply Wound VAC with 125 mm/hg (millimeters of mercury) continuous pressure 3 times a week every day shift on Monday, Wednesday, Friday. Review of Resident #86's Treatment Administration Record (TAR) and Medication Administration Record (MAR) from 3/17/25 through 3/20/25 revealed the wound vac was not applied to Resident #86. The Wound Vac order was discontinued on 3/20/25 by the Wound Care Physician. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to apply saline wet to dry dressings to the left ischium every day until the wound vac is available. This order was not signed as administered on 3/17/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order with a start date of 3/18/25 to cleanse the left ischium with normal saline, apply wet to dry saline moist gauze and cover with foam dressing until the Wound Vac arrives then discontinue. This order was signed as administered on 3/18/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to cleanse open area to right hip with normal saline and apply wet to dry saline gauze and cover with foam dressing as needed. This order was not signed as administered on 3/17/25. The order was changed on 3/18/25 to every day shift and was signed as administered on 3/18/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to cleanse open area to sacrum and apply Calcium Alginate (a wound dressing used for moderate to heavy exuding wounds to create a moist healing environment, absorbs drainage and controls minor bleeding), and cover with foam dressing as needed. This order was changed to every day shift on 3/18/25 and signed as administered on 3/18/25. Review of the Treatment Administration Record (TAR) for Resident #86 revealed an order dated 3/17/25 to cleanse open

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews the facility failed to provide care in a safe manner when Nurse Aide #8 provided incontinence care to a resident (Resident #39). This resulted in Resident #39 rolling off of the bed onto the floor sustaining a fracture to the first cervical vertebrae (C1) of the cervical spine. This occurred for 1 of 5 residents reviewed for accidents (Resident #39). Resident #39 was admitted to the facility on [DATE]. Her diagnoses included cerebral vascular accident (CVA), hemiplegia (paralysis or weakness on one side of the body), and dementia. A care plan dated 4/18/25 revealed Resident #39 required assistance with activities of daily living (ADLs) including bed mobility due to having limited mobility related to cerebral vascular accident (CVA) with hemiplegia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #39 was severely cognitively impaired. She had no falls at the time of the assessment. Her weight was 168 pounds. She required extensive two-person assistance with bed mobility, and activities of daily living. A fall incident report dated 9/7/25 at 10:10 PM written by Nurse #9 revealed Nurse Aide #8 yelled for help. Nurse #9 entered the room and Resident #39 was lying on the floor on her side and partially on her stomach. A puddle of blood was noted under Resident #39's head. Nurse #9 applied pressure to the area to slow the bleeding. No other injuries were observed other than the laceration to the top of the forehead where the blood was coming from and possible guarding of the right arm. Emergency Medical Services (EMS) was immediately notified. Nurse #9 stayed with Resident #39 until EMS arrived. Resident #39 was unable to give a description of what happened. The Physician, Director of Nursing, and the Responsible Party were notified. Resident #39 was transported to the hospital for evaluation. The hospital summary dated 9/7/25 at 11:52 PM revealed Resident #39 presented to the emergency department after a witnessed fall. According to the report Resident #39 rolled off the bed while being changed. Resident #39 had a history of CVA and dementia at baseline. Computed Tomography (CT) of the cervical spine showed a nondisplaced fracture on the lateral margin of C1 (first cervical vertebrae) with no other abnormalities involving the cervical spine. A cervical collar was placed. The CT also revealed a midline frontal scalp soft tissue laceration with no underlying fracture. Resident #39 was transferred to a tertiary care facility (provides highly specialized medical services) for further evaluation. The hospital summary from the tertiary care facility revealed Resident #39 admitted on [DATE] and discharged back to the skilled nursing facility on 9/8/25. Resident #39's diagnoses was C1 fracture of the cervical spine with no surgical interventions needed. A progress note dated 9/8/25 at 3:36 PM written by Unit Manager #1 revealed a call was received from the hospital. Resident #39 was returning back to the facility with a C1-nondisplaced fracture with no neurosurgical involvement. Resident #39 was to wear the cervical collar at all times and follow up in 4 weeks. The facility investigation report dated 9/8/25 revealed on 9/7/25 at approximately 10:30 PM Nurse Aide #8 stated while providing care for Resident #39 she positioned Resident #39 who was severely cognitively impaired on her left side to begin washing her because of a bowel movement. Nurse Aide #8 began to change the sheets while providing care. Nurse Aide #8 had one hand placed on Resident #39 and the other hand was used to make the bed. Resident #39 began to wiggle and fell off the bed on to her left side. Nurse Aide #8 immediately called for help never leaving the residents side. Nurse #9 ran into the room and assisted in providing emergency care. Nurse #9 called for the charge nurse and they both stayed with Resident #39 to provide care until EMS arrived. Resident #39 was observed with blood pooling from her head from a laceration and guarding of her right arm. First Aide was rendered to stop the bleeding. The on-call physician was notified. Resident #39 was transferred to the hospital for evaluation. The hospital report revealed a nondisplaced fracture of C1 (first vertebrae of cervical spine). A written statement dated 9/8/25 made by the Regional Corporate Consultant during the facility's investigation revealed Nurse Aide #8 was called to return to the facility to perform a return demonstration of Resident #39 sliding out of the bed onto the floor. This writer along with the Director of Nursing and the Administrator assisted Nurse Aide #8 to room [ROOM NUMBER]. Nurse Aide #8 stated she went into Resident #39's room to provide incontinence care. Nurse Aide #8 explained that Resident #39 was positioned on her back, and she assisted her to her left side and began to provide incontinence care. Nurse Aide #8 stated during care Resident #39 began to move to the edge of the bed. Bolsters (a long cylindrical pillow used for support, which also acts as a safety barrier) were in place on both sides of the bed. While on her left side Resident #39 rolled off of the bed onto the floor. Nurse Aide #8 was unable to prevent her from sliding off of the bed. Resident #39 landed on her right side

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the Consultant Pharmacist, and the Medical Director interviews the facility failed to have effective safeguards and systems in place to prevent drug diversion of discontinued narcotic pain medication (Hydrocodone-Acetaminophen oral tablet 5-325 milligrams) which resulted in a total of 20 missing tablets. This occurred for 1 of 1 resident (Resident #3) reviewed for misappropriation of medications. Findings included: Resident #3 was re-admitted to the facility on [DATE] with diagnoses including a stage IV and stage II pressure wounds. A hospital physician's order dated [DATE] for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for up to 5 days. A second hard copy physician's order dated [DATE] for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 mgs. Give 1 tablet by mouth every 6 hours as needed for pain for 14 days (56 tablets). This order was not entered into the electronic medical record. A packing slip and proof of delivery from the dispensing pharmacy dated [DATE] revealed the hospital physician's order was filled with a delivery of 11 tablets of Hydrocodone-Acetaminophen oral tablets 5-325 mgs for Resident #3 was received in the facility on [DATE]. The delivery was signed as received by Nurse #7. A packing slip and proof of delivery from the dispensing pharmacy dated [DATE] revealed the facility's physician's order was filled with a delivery of Hydrocodone-Acetaminophen oral tablets 5-325 mg and a total of 54 tablets for Resident #3 was received in the facility on [DATE]. The delivery was signed as received by Nurse #7 and Nurse #5. The declining count sheet for the 11 tablets of Hydrocodone-Acetaminophen 5-325 mgs ordered on [DATE] by the hospital physician and the Medication Administration Record (MAR) dated [DATE] included corresponding information indicating that the medication was signed by nursing staff as administered to Resident #3 from [DATE] through [DATE] with zero tablets remaining. The MAR had a stop date of [DATE]. The declining count sheet for the [DATE] order for the 54 tablets of Hydrocodone-Acetaminophen 5-325 mgs ordered by the facility's physician and Resident #3's MAR were reviewed. The July and [DATE] MARs revealed the hard copy order from the facility physician's dated [DATE] was not entered on Resident #3's MAR. The declining count sheet and the MAR revealed the following information related to this Hydrocodone-Acetaminophen order: - [DATE] at 2:00 PM: On the declining count sheet one tablet was signed as administered by Nurse #9 with 53 pills noted as remaining. This was documented on the MAR on the 5-day under the order given by the hospital physician on [DATE]. - [DATE] at 8:00 PM: On the declining count sheet one tablet was signed as administered by Nurse #7 with 52 pills noted as remaining. There was no documentation on the MAR corresponding to the declining count sheet. - [DATE] with no time documented: On the declining count sheet one tablet was signed out by a nurse whose name was not legible with 51 pills noted as remaining. There was no documentation on the MAR corresponding to the declining count sheet. A new physician's order dated [DATE] for Resident #3 revealed Hydrocodone-Acetaminophen 5-325 mgs 1 tablet by mouth every 6 hours as needed for pain for 14 days. This order was on the MAR with a stop date of [DATE]. The [DATE] as needed order for Hydrocodone-Acetaminophen was signed out as administered on the declining count sheet from the [DATE] order for the 54 tablets delivered by the pharmacy on [DATE]. The declining count sheet and the September MAR revealed the following information: - [DATE] at 8:50 AM one tablet was signed as administered by Nurse #9 and documented on the September MAR. There were 50 pills remaining. - [DATE] at 4:20 PM one tablet was signed as administered by Nurse #9 and documented on the September MAR. There were 49 pills remaining. - [DATE] at 7:00 AM one tablet was signed as administered by Nurse #10 and was not documented on the September MAR. There were 48 pills remaining. - [DATE] at 7:00 AM one tablet was signed as administered by Nurse #10 and was not documented on the September MAR. There were 47 pills remaining on the 54-count card. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #3 was cognitively intact. He received scheduled and as needed opioid medications with occasional pain. An investigation report completed by the Administrator dated [DATE] revealed an order for Hydrocodone-Acetaminophen 5-325 mgs was given by the hospital. Eleven tablets were delivered to the facility on [DATE] and signed in by Nurse #7 and Nurse #5. Nurse Practitioner #1 placed an additional order on [DATE] and 54 tablets were delivered on [DATE] and signed in by Nurse #9. The 11 Hydrocodone-Acetaminophen 5-325 mgs were completed on [DATE]. The descending count for the 2nd card of 54 tablets was 49 on [DATE]. On [DATE] Nurse #10 discovered the count on the narcotic sheet had been

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the Consultant Pharmacist's interview the facility failed to act on the Pharmacist's recommendation to remove a residents (Resident #3) discontinued narcotic pain medication (Hydrocodone- Acetaminophen 5-325 milligrams) from the medication cart. This resulted in 20 missing tablets. This occurred for 1 of 6 residents (Resident #3) reviewed for medication administration.Findings included:Resident #3 was re-admitted to the facility on [DATE] with diagnoses including a stage IV pressure wound and osteomyelitis (infection of the bone). A hospital physician's order dated 7/14/25 for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for up to 5 days beginning 7/14/25. This order was administered to Resident #3 from 7/15/25 through 7/19/25 and completed. A second hard copy physician's order dated 7/14/25 for Resident #3 revealed Hydrocodone-Acetaminophen oral tablets 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for pain for 14 days (56 tablets). A packing slip and proof of delivery from the dispensing pharmacy dated 7/15/25 revealed the facility physician's order was filled with a delivery of Hydrocodone-Acetaminophen oral tablets 5-325 mg and a total of 54 tablets for Resident #3 was received in the facility on 7/15/25. The delivery was signed as received by Nurse #7 and Nurse #5. The declining count sheet for the 54 tablets of Hydrocodone-Acetaminophen 5-325 mgs for Resident #3 was signed out by nursing staff as needed during the month of July 2025 and signed as administered one time in August 2025. Review of the Consultant Pharmacist's Controlled Substance Random Audit form dated 8/14/25 conducted by Consultant Pharmacist #2 revealed Resident #3 was selected for a random medication audit. The Pharmacist noted that Resident #3's Hydrocodone-Acetaminophen 5-325 mg order had been discontinued in July 2025 and to pull the medication card from the cart and return to pharmacy. An investigation report completed by the Administrator dated 11/5/25 revealed in part; On 11/5/25 Nurse #10 discovered the count on the narcotic sheet noting 20 missing tablets of Hydrocodone-Acetaminophen and reported this to the Director of Nursing (DON). During a phone interview on 11/18/25 at 2:30 PM the Consultant Pharmacist (#2) who was the consultant during July through September 2025 stated she did random audits on the controlled medications and randomly selected 4 or 5 cards for auditing at each visit. She stated she looked at documentation, final counts, and verified that the card and the order matched. The Consultant Pharmacist stated a note was sent to the Director of Nursing (DON) regarding Resident #3's Hydrocodone - Acetaminophen 5-325 mgs that remained on the medication cart on the August 2025 pharmacy report. The Consultant Pharmacist stated the note read to pull the Hydrocodone - Acetaminophen 5-325 mg for Resident #3 from the medication cart and return to the Pharmacy for disposal because the order was discontinued on 7/29/25 after 14 days. She stated she typically did not go back and review the previous months recommendations that were sent to the Director of Nursing (DON) and just expected the recommendations would be followed. During an interview on 11/18/25 at 10:45 AM the Director of Nursing (DON) indicated she was responsible for acting on the monthly pharmacy reports. She stated she received the Consultant Pharmacist's medication audit reports each month and would complete the necessary recommendations when she received the report. The DON indicated that the Pharmacist's note to pull Resident #3's discontinued medication from the medication cart on the 8/14/25 review was missed in error. The DON stated had the Hydrocodone- Acetaminophen been removed after the order was discontinued or at least removed after the Consultant Pharmacists recommendations the missing medications would not have occurred.

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, the Pharmacy District Director, and the Wound Physician interviews, the facility failed to administer two intravenous (IV) antibiotics (Piperacillin Sodium Tazobactam - a broad-spectrum antibiotic used to treat moderate to severe bacterial infections and Vancomycin - an antibiotic used to treat severe infections) prescribed for the treatment of osteomyelitis (infection of the bone) following admission for a resident (Resident #86). This resulted in 4 missed doses of the Piperacillin and 4 missed doses of the Vancomycin. This occurred for 1 of 6 residents reviewed for medication administration. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Piperacillin Sodium Tazobactam. Use 3.375 grams intravenously every 8 hours for osteomyelitis for 18 days. The hospital discharge instructions dated 3/15/25 revealed an order for Resident #86 for Vancomycin intravenous solution. Use 1 gram intravenously two times a day for osteomyelitis until 04/03/25. Resident #86 was admitted to the facility on [DATE] with diagnoses including a Stage IV pressure ulcer of the left ischium (the lower and back portion of the hip bone), Stage IV pressure ulcer on the sacrum, Stage IV pressure ulcer of the right hip, Stage II pressure ulcer on the right buttock, a deep tissue injury of the left heel, osteomyelitis of the vertebra, sacral, coccyx region, and left thigh, and paraplegia (paralysis of the lower extremities). Review of the Medication Administration Record (MAR) dated March 2025 for Resident #86 revealed the first dose of Piperacillin Sodium scheduled for every 8 hours was not administered until 3/17/25 at midnight, the second dose was administered at 8:00 AM on 3/17/25, the third dose was administered at 8:00 PM on 3/17/25. Review of the Medication Administration Record (MAR) dated March 2025 for Resident #86 revealed the first dose of Vancomycin to be administered two times a day for osteomyelitis was not administered until 3/17/25 at 8:00 PM. Review of Resident #86's progress notes on 3/15/25 and 3/16/25 revealed no documentation as to why the antibiotics were not administered. A progress note was entered by the Social Worker on 3/15/25 at 1:34 PM indicating Resident #86 was in the facility at that time. Review of Resident #86's Vancomycin trough level (the lowest concentration of Vancomycin in the blood, measured just before the next dose is administered. Monitoring the trough level helps to ensure the drug is effective while minimizing the risk of toxicity) that was ordered on 3/17/25 then weekly showed Resident #86 was in therapeutic range. During a phone interview on 11/18/25 at 10:30 AM Unit Manager #1 stated Resident #86 admitted on Saturday 3/15/25 with stage IV pressure wounds and orders for IV antibiotics. Unit Manager #1 indicated the nurses could enter physician orders, but she was responsible for reviewing that the admission orders were entered. She realized the antibiotic orders had not been entered into Resident #86's electronic medical record upon admission on [DATE]. Unit Manager #1 stated she at times entered orders from home and she was the one that entered the antibiotic orders for Resident #86 and that was why the antibiotic orders did not populate on the MAR to be administered until 3/17/25. She stated the admitting nurse should have sent the antibiotic orders to the pharmacy and entered the antibiotic orders on 3/15/25 the day of admission, but that did not occur. Unit Manager #1 indicated Medication Aide #1 was assigned to the hall that Resident #86 was admitted to on 3/15/25 and 3/16/25. The responsible day shift nurse (Nurse # 12) and night shift nurse (Nurse #11) on 3/15/25 and 3/16/25 were agency staff and were no longer employed by the facility. During a phone interview on 11/18/25 at 7:00 PM Medication Aide #1 stated the nurse in charge would have handled IV medications, but she did not recall what medications Resident #86 received. During a phone interview on 11/21/25 at 11:30 AM the Pharmacy District Director stated they provided 24-hour services 7 days a week to the facility. If IV medications were ordered over the weekend the medications would be delivered over the weekend. She stated Resident #86's Vancomycin order was not received in the pharmacy until 3/16/25 at 9:32 PM and it was delivered to the facility Monday 3/17/25. The Piperacillin order was received in the pharmacy on 3/16/25 at 3:31 AM and delivered to the facility on 3/16/25. During a phone interview on 11/21/25 at 12:30 PM the Wound Physician stated missing doses of Vancomycin and Piperacillin in the treatment of osteomyelitis was significant and could delay wound healing. The Wound Physician stated she could not say the missed doses caused any worsening of the infection regarding Resident #86 but missed doses could lead to subtherapeutic levels causing the antibiotic to be less effective. During a phone interview on 11/21/25 at 1:00 PM the Director of Nursing (DON) stated the orders for Resident #86's IV antibiotics should have been entered into the electronic medical and sent to Pharmacy on 3/15/25 the day of admission. The DON indicated that the IV antibiotics should have been administered to Resident #86 sooner

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and staff interviews, the facility failed to 1) secure an unattended medication cart that was facing the hallway for 13 minutes during which time 3 staff members and a resident propelling himself in a wheelchair passed the unattended opened medication cart for 1 of 1 medication carts observed (400 hall medication cart), and 2) remove loose and unsecured pills (200 hall cart), label inhalation breathing medication vials with an open date and store the vials according to manufacturer guidelines (300 hall cart) for 2 of 4 medication carts and failed to discard expired over the counter (OTC) stock medication from 1 of 2 medication storage rooms (200 hall medication room) that were reviewed for medication storage. Findings included: 1) A continuous observation of the 400-hall medication cart on 10/02/25 from 10:10 AM to 10:23 AM revealed the medication cart was noted to be unlocked as evidenced by the lock base not being pushed in flush with the drawer and was unattended and facing the hallway. Three staff members were noted to walk past the medication cart during this observation and one resident who was self-propelling in a wheelchair was noted to pass by the unlocked medication cart. An interview was conducted with Unit Manager #2 on 10/02/25 at 10:23 AM. The Unit Manager exited a resident's room and approached the 400-hall medication cart. At this time, she locked her medication cart. Unit Manager #2 stated she did not realize she left the medication cart unlocked until she came out of the residents' room. She stated she forgot to lock it before she walked away from it. An interview was conducted with Director of Nursing (DON) on 11/18/25 at 10:43 AM. The DON stated she would expect all the nursing staff to keep their medication carts locked if they were out of direct line of site and all medication carts should be secured for resident safety. 2. An observation of the 200-hall medication cart was conducted with Nurse #8 on 10/1/25 at 10:10 AM. The observation revealed 11 loose pills of various shapes, colors, and sizes in the bottom of the medication drawers. An interview was completed with Nurse #8 on 10/1/25 at 10:15 AM. Nurse #8 stated the nurses and medication aides (MA) were responsible for cleaning and checking the med carts every shift. She indicated there was not supposed to be any loose pills in the med cart drawers. An interview was completed with the Director of Nursing (DON) on 11/18/25 at 2:52 PM. The DON stated the nurses and medication aides were all responsible for keeping the med carts clean and orderly. She indicated there should not be any loose pills in the med cart drawers. She stated she expected med carts to be clean and free from loose pills. 3. An observation of the 200-hall medication storage room was completed with Unit Manager #1 and Nurse #8 on 10/1/25 at 10:17 AM. A bottle of the over the counter (OTC) stock Vitamin B6 50 milligrams (mg) tablets was available for use with an expiration date of 8/25. An interview was completed with Unit Manager #1 on 10/1/25 at 10:25 AM. Unit Manager #1 stated there should not be any expired medications on the shelf available for use in the medication storage rooms. (continued on next page)

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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	310 E Wardell Drive Pembroke, NC 28372

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with the DON on 10/2/25 at 10:30 AM. The DON stated there should not be any expired medications available for use in the medication storage rooms. 4. An observation of the 300-hall med cart was conducted on 10/2/25 at 10:13 AM with the Wound/Treatment Nurse. The observation revealed 20 vials of ipratropium bromide inhalation solution in an open foil package with no label or date opened. The manufacturer's instructions included discarding the medication 2 weeks after opening. An interview was completed with the Wound/Treatment Nurse on 10/2/25 at 10:25 AM. The Wound/Treatment Nurse stated she was unaware the vials expired 2 weeks after opening and it should have had an opened date. An interview was completed with the DON on 10/2/25 at 10:30 AM. The DON stated she was not aware that the vials expired 2 weeks after opening. She indicated all medications should have a label and an opened date.