

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/20/2026
NAME OF PROVIDER OR SUPPLIER  Pembroke Center		STREET ADDRESS, CITY, STATE, ZIP CODE  310 E Wardell Drive Pembroke, 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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews, and interviews with staff, Director of Nursing, Pharmacist, Administrator, and the Medical Director, facility failed to verify right patient before administering insulin, which resulted in an insulin injection being administered to a resident with the same last name without an insulin order for 1 of 1 resident reviewed for significant medication errors (Resident #19). The findings included: Resident #19 was admitted to the facility on [DATE] with diagnoses of influenza, pneumonia, and did not include diabetes (DM).Resident #19's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #19 was cognitively intact. Resident #19's physician orders for January/2026 listed: Oxygen at 3 liters nasal cannula, albuterol, digoxin, and metoprolol. The physician orders did not include an order for insulin. Review of Resident #19's Electronic Medication Administration Record (E-MAR) dated January 2026 revealed no order listed for insulin.A nursing note dated 01/12/26 at 7:24 PM for Resident #19 revealed on 01/12/26 at 4:30 PM the resident was given 10 units of Lispro insulin and was not on insulin. Resident #19 was given glucose by doctor's order. Resident's blood glucose on 01/12/26 at 6:28 PM was 149. Patient's blood sugar levels were monitored and remained within normal limits, with patient stable. (Insulin lispro is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours.) (Normal blood sugar levels for non-diabetic adults range from 70 to 140). A Medical Director order dated 01/12/26 at 5:00 PM for Resident #19 revealed to administer one tube (24 grams) of Insta-glucose gel stat, which was given. (Insta-glucose gel is a fast-acting glucose used to treat very low blood sugar.) An interview was conducted on 01/14/26 at 9:10 AM with Nurse #1. The nurse said on 01/12/26 around 4:30 PM she was working on the medication cart on the 300-hall. She said she administered 10 units of Lispro (insulin) to Resident #19 instead of intended resident with the same last name. She said she immediately reported the medication error to the Unit Manager, who notified the Nurse Practitioner, who ordered glucose gel to be administered, vital signs and assessment done, along with 15-minute blood glucose levels check, which she did. Nurse #1 stated resident's blood sugar remained within normal limits and Resident #19 had no side effects. She said the Medical Director and resident's Responsible Party (RP) were informed of the medication error. Nurse #1 said she gave the insulin in error, was distracted, and should have paid closer attention to giving out medications to residents with the same last name.An interview was conducted on 01/13/26 at 3:48 PM with Unit Manager #2. She said on 01/12/26 around 4:30 PM she was working on the 400 short hall. She said Nurse #1 came to her and said she gave 10 units of insulin to the wrong resident. The Unit Manager said she immediately checked Resident #19's blood sugar which was 100, then reported the incident to the Director of Nursing and the Nurse Practitioner, who ordered glucose gel to be administered, vital signs and assessment done, along with blood glucose levels checked. Unit manager stated resident's blood sugar remained within normal limits and Resident #19 had no side effects from the insulin. Resident #19's blood sugar levels: 01/12/25 at 5:02 PM - 100, 01/12/25 at</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345409
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5:18 PM - 114, 01/12/25 at 6:28 PM - 149, 01/12/25 at 9:00 PM - 100, 01/12/25 at 11:00 PM - 115, and 01/13/25 at 1:19 AM - 103. An interview was conducted on 01/13/26 at 3:25 PM with Resident #19. The resident stated on 01/12/26 just before dinner she was given an insulin injection in her right arm by Nurse #1. She stated after the injection, she asked the nurse what she gave her and was told her evening insulin. The resident told the nurse that she was not diabetic and was not on insulin. Resident #19 stated she had no reactions from the insulin, and soon after getting the injection, she was given glucose gel and was monitored by nursing staff. An interview was conducted on 01/14/26 at 9:36 AM with the Director of Nursing (DON). She stated it was her expectation that Nurse #1 followed their policy on medication errors and to have verified the right resident, the right medication, the right dose, and right route; before she administered the 10 units of Lispro (insulin) to Resident #19. An interview was conducted on 01/14/26 at 9:55 AM with the facility's Pharmacist. She confirmed Resident #19 received 10 units of Lispro insulin in error on 01/12/26 around 5:15 PM. The Pharmacist indicated Nurse #1 mistakenly gave the insulin to the wrong resident and noted the resident who was prescribed the insulin and Resident #19 both had the same last name. She said the only possible drug interaction was that of metoprolol, which could mask the effects of hypoglycemia. However, Resident #19 only received one 10-unit low dose of insulin, and was taking metoprolol in the mornings, which most likely wouldn't have this masking effect. The Pharmacist said the resident's blood sugar was closely monitored for about 2 hours after the 10-unit insulin administration, with no drug interactions. The Pharmacist stated a normal adult's blood sugar was 80 to 90, and that Resident #19 blood sugar checks after the one dose insulin administration was never below 100 and remained above the normal adult blood sugar range. An interview was conducted on 01/13/26 at 3:20 PM with the Medical Director. He confirmed on 01/12/26 at approximately 4:30 PM Resident #19 was accidentally administered 10 units of Lispro (insulin) that was intended for another resident with the same last name during medication pass. He said the nurse notified her unit manager; resident was assessed with vital signs and blood sugar check, was given glucose per order, and remained stable with blood sugar of 100, with no aftereffects, and no harm. A follow-up Medical Director progress note for Resident #19 dated 01/14/26 at 10:57 AM stated: [Resident #19] was noted to have received on 01/12/26 insulin Lispro (generic Humalog) 10 units in error. [Resident #19] sustained no adverse effect. Indeed, 10 units is not considered a high dose, and in this case, the likelihood of any adverse effects was nil. Moreover, the actions of the staff member in administering glucose gel, further ensured that any adverse effects were not likely to occur. Therefore, the likelihood for harm in this case was nil. An interview was conducted on 01/14/26 at 9:49 AM with the Administrator. She stated it was her expectation that Nurse #1 followed their policy on medication errors and to have verified the right resident, before she administered the 10 units of insulin to Resident #19, which she did not do.</p>		