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 _____	05/04/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey) recertification survey conducted on 05/04/11.	F 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/07/2011

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

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K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: Fire/smoke wall in attic on 300 and 400 hall had unsealed penetrations that were not seal to maintain construction rating of wall. Penetration must be sealed with approved fire caulk. 42 CFR 483.70(a)	K 025	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Pembroke Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency K 025 1. Unsealed penetrations in the fire/smoke wall in attic on 300 and 400 halls were sealed with approved fire caulk by Director of Maintenance on June 17, 2011 in order to maintain construction rating of wall. 2. Remaining fire/smoke walls in the attic were inspected by Director of Maintenance for any penetrations on June 24, 2011. No other penetrations were found. 3. Director of Maintenance was re-educated by the Administrator on June 24, 2011 related to penetrations with the fire/smoke walls in the attic areas. 4. Director of Maintenance will audit/inspect fire/smoke walls in the attic areas, weekly for 3 months, to be sure that any previous penetrations remain sealed and no new penetrations occur. The results of the audit/inspection will be reviewed by Director of Maintenance for trends and present findings to the Performance Improvement Committee monthly for 3 months. Administrator and Director of Maintenance will be responsible for overall compliance. Compliance date: July 15, 2011	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/24/11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CARE AND REHABILITATION 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
K 038	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: office doors(business,payroll and admission) require two motion of hand to open door to exit egress. Also, when staff was interview on how to open doors with special locking, they did not know were switch was located at nurse station. 42 CFR 483.70(a)	K 038	K 038 1. a. Business, Payroll and Admissions office door handles will be removed on or before July 15, 2011 and replaced with door knobs to allow exit egress with single motion of hand. b. Staff were immediately re-educated regarding the master door release switches by Staff Development Coordinator on June 7, 2011. 2. a. Doors in facility were audited/inspected by Director of Maintenance on June 8, 2011and single-motion door knobs will be installed as required on or before July 15, 2011. 3. Staff Development Coordinator will re-educate staff members on or before July 15, 2011 regarding master door release switches that release the electro-magnetic locks on the exit doors. 4.a. Director of Maintenance will audit door knobs in facility, weekly for 3 months, to insure that they allow exit egress with single motion of the hand. b. Staff development Coordinator will interview staff members on each shift, weekly for 3 months, regarding master door release switch locations and document results. The results of the audit/inspection for door knobs/master door release switches will be reviewed by Director of Maintenance for trends and presented to Performance Improvement Committee monthly for 3 months. Administrator and Director of Maintenance will be responsible for overall compliance. Compliance date: July 15, 2011	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: closet in rooms 101 and 108 had storage	K 056		

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K 056	Continued From page 2 within 18 inches of sprinkler head. 42 CFR 483.70(a)	K 056	K 056 1. Items in closets in room 101 and room 108 within 18 inches of sprinkler head were relocated away from sprinkler heads on June 7, 2011 by Director of Environmental Services. 2. Closets and storage areas with sprinkler heads were audited/inspected by Director of Environmental Services on June 24, 2011 to insure that nothing was being stored within 18 inches of any sprinkler head. 3. The staff were re-educated by Staff Development Coordinator on June 24, 2011 related to keeping items at least 18 inches away from sprinkler heads. 4. Director of Maintenance will audit closets and storage areas, weekly for 3 months, to insure that no items are stored within 18 inches of installed sprinkler heads. The results of the audit/inspection will be reviewed by Director of Maintenance for trends and presented to Performance Improvement Committee monthly for 3 months. Administrator and Director of Maintenance will be responsible for overall compliance. Compliance date: July 15, 2011	