JASS69 E. WHO C INME OF PROVIDER OF SUPPLIER STREET ADDRESS, GTV, STATE, 2P CODE 390 E WARDELL DRVE PEMBROKE CENTER STREET ADDRESS, GTV, STATE, 2P CODE 390 E WARDELL DRVE Common Street ADDRESS, GTV, STATE, 2P CODE PMI (0) SUMMANY STREMENT OF DEFICIENCIES (EACH DEFICIENCY WAST EFFRENCED FOR STALL (EACH DEFICIENCY) Deficiencies Common Street (Comparison of the APROPRIATE (Comparison of the Apropriate (Commanison of the APROPRIATE (Comparison of the Apropriate (Commanison of the Apropriate (CR) comparison (Comparison of the Apropriate (CR) comparison (COM) and the Apropriatis of the Apropriate (CR) comparison (Comparison of the Apropria		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STATE, ZP CODE STREET ADDRESS, CTY, STATE, ZP CODE PEMBROKE CENTER STREET ADDRESS, CTY, STATE, ZP CODE STREET ADDRESS, CTY, STATE, ZP CODE Image: Comparison of the complexity of thematter the complexity of the complexity of thematt			345409		B WING		
PEMBROKE CENTER 319 E WARDELL DRIVE PERFORME, NC 23372 (M4) D. PRETY. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIBED BY FULL TXG D. PRETY. D.			545409			05	/03/2018
PEMBROKE CENTER PEMBROKE, NC 28372 (M) ID TRG SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EF RECED BY FULL (EACH DEFICIENCY WIST EF RECED BY FULL (EACH DEFICIENCY) PEMBROKE, NC 28372 F 000 INITIAL COMMENTS F 000 PERIMINARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) PEND (EACH DEFICIENCY) Softward (EACH DEFICIENCY)		CONDER OR SOLT EIER					
PREFIX TAG (EACH CORFECTS MUST BE FRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING BROWNTON) PREFIX TAG (EACH CORFECTIVE ACTION SHOULD BE DEFICIENCY) COMMENTE DEFICIENCY F 000 INITIAL COMMENTS F 000 F 000 F 641 F 641 See OFRE(S): 483.20(g) S/16/18 S 483.20(g) Accuracy of Assessments SS=0 F 641 F 641 F 641 F 641 S/16/18 Level II determination for 2 of 2 residents (Resident #10 and #44) and failed to document the correct discharge destination for 1 of 3 residents (Resident #55) whose Minimum Data Set (MDS) assessments. Tailure, dependence on ventilator, tracheostomy, dementi, schizophrenia, catatoric disorder due to known physiological condition, major depression, and extrapyramidal and movement disorder. 1. Modifications were made to the Minimum Data Set for lass to days 220/2018- 5/1/2018 Residents were identified with incorrect conding. Clinical Review of the Admission MDS assessment for Resident #10 had severely impaired cognition, never or rarely understood, and was totally dependent on staff for all care. The assessment did not reflect a PASRR Level II determination status. 2. Clinical Reimbursement Coordinator conducted a 100% audit of residents were identified with incorrect coding. Clinical Review of the North Carolina Department of Health and Human Services, Division of Medical Assistance Level II Evaluation Report dated 3. Regional Clinical Reimbursement Coordinator conducted a 100% audit of resident and condinator conducted a 100% audit of all residents PASR for accuracy. <th>PEMBROM</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>	PEMBROM						
No deficiencies were cited as a result of the complaint investigation. Event ID N9NX11. 5/16/18 F 641 Accuracy of Assessments 5/16/18 SS=D CFR(s): 483.20(g) F 641 \$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. F 641 5/16/18 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document the correct DASRR Level II determination for 2 of 2 residents Nodifications were made to the Minimum Data Set for Resident#10, Resident #10 and #44) and failed to document the correct disABRR level II determination for 1 of 3 resident #10 was readmitted to the facility on 02/2218 with diagnoses that included respiratory failure, dependence on ventiliator, tracheostomy, dementia, schizophrenia, catatoric disorder due to known physiological condition, major depression, and extrapyramidal and movement disorder. 2. Clinical Reimbursement Coordinators (CRC) completed 100% audit of Fol/2018 of Minimum Data Set for last 90 days 2/202018. 5/1/2018 for those residents were lidentified with incorrect coding. Clinical Reimbursement Coordinator conducted a 100% audit of resident with PASRR level II on 5/3/2018 Resident sidentified with incorrect PASRR level II on 5/3/2018 Resident with PASRR level II on 5/3/2018 by the Clinical Reimbursement coordinator and to all coordinator provided re-education to the Clinical Reimbursement Coordinator and to fail cate. The assessment of Heatth and Human Services, Division of Medical Assistance Level II Evaluation Report dated	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETIO
complaint investigation, Event ID N9NX11.F 6415/16/18Accuracy of Assessments Stass 20(g)F 6415/16/18\$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.F 6411. Modifications were made to the Minimum Data Set for Resident#10, Resident#10 and #44) and field to document the correct discharge destination for 1 of 3 resident #10 and #44) and field to document the correct discharge destination for 1 of 3 resident #10 was readmitted to the facility on 02/22/18 with diagnoses that included respiratory failure, dependence on ventilator, tracheostomy, dementa, schizophrenia, catalactic disorder due to known physiological condition, major depression, and extrapyramidal and movement disorder.2. Clinical Reimbursement Coordinators (CRC) completed 100% audit on 59/2018 of Minimum Data Set for last 00 days 2/20/218-5/1/2018 for those residents who discharged from facility and the destination. No other residents were identified and was totally dependent on staff or all care. The assessment did not reflect a PASRR Level II determination status.2. Regional Clinical Reimbursement Coordinator conducted a 100% audit of all one 3/3/2018 pt the Clinical Reimbursement Coordinator conducted a 100% audit of all resident #10 and severely impaired cognition, never or rarely understood, and was totally dependent on staff or all care. The assessment did not reflect a PASRR Level II determination status.3. Regional Clinical Reimbursement Coordinator conducted a 100% audit of all residents for all care. The assessment did not reflect a PASRR Level II determination status.Review of the North Carolina Department of Health and Human Services, Division of Medical Assistance Level II Evaluation Report date	F 000	INITIAL COMMENTS	6	F 00	0		
F 641 SS=D Accuracy of Assessments CFR(s): 483.20(g) F 641 5/16/18 § 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document the correct PASRR Level II determination for 2 of z residents (Resident #10 and #44) and failed to document the correct discharge destination for 1 of 3 resident (Resident #50) whose Minimum Data Set (MDS) assessments were reviewed. 1. Modifications were made to the Minimum Data Set for Resident#10, Resident #41, on 05/03/2018. The modification for Resident#55 included changing A1500. 1510 and A2100 were modified to reflect the correction to Discharge location coding and PASRR levels. 1. Resident #10 was readmitted to the facility on 02/22/18 with diagnoses that included respiratory failure, dependence on ventilator, tracheostomy, dementia, schizophrenia, catatonic disorder due to known physiological condition, major dependent on staff for all care. The assessment disorder. 2. Clinical Reimbursement Coordinators (CRC) completed 100% audit of Psi/2018 of Minimum Data Set for last 90 days 22/20/218-51/2018 for those residents who discharged from facility and the destination. No other residents were identified with incorrect coding. Clinical Reimbursement Coordinator conducted a 100% audit of resident with PASRR level II on 5/3/2018 by the Clinical Reimbursement Coordinator conducted a 100% audit of all residents PASRR for accuracy. Review of the North Carolina Department of Health and Human Services, Division of Medical Assistance Level II Evaluation Report dated 3. Regional Clinical Reimbursement Coordinator provided re-education to the Clinical Reimbursement Coordinator and							
§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document the correct PASRR Level II determination for 2 of 2 residents (Resident #10 and #44) and failed to document the correct discharge destination for 1 of 3 residents (Resident #55) whose Minimum Data Set (MDS) assessments were reviewed. 1. Modifications were made to the Minimum Data Set for Resident#10, Resident #10 and #44) and failed to document the correct discharge destination for 1 of 3 resident #10 has readmitted to the facility on 02/22/18 with diagnoses that included respiratory failure, dependence on venitilator, tracheostomy, dementia, schizophrenia, catatonic disorder due to known physiological condition, major depression, and extrapyramidal and movement disorder. 2. Clinical Reimbursement Coordinators (CRC) completed 100% audit on 5/9/2018 of Minimum Data Set for last 90 days 2/20/2018-5/1/2018 for those residents who discharged from facility and the destination. No other residents were identified with incorrect coding. Clinical Review of the Admission MDS assessment did not reflect a PASRR Level II determination status. 2. Clinical Reimbursement Coordinator conducted a 100% audit of resident with PASRR level II on 5/3/2018 Residents identified with incorrect PASRR levels were modified on 5/3/2018 D ty the Clinical Reimbursement Coordinator conducted a 100% audit of all residents PASRR for accuracy. Review of the North Carolina Department of Health and Human Services, Division of Medical Assistance Level II Evaluation Report dated 3. Regional Clinical Reimbursement Coordinator provided re-education to the Clinical Reimbursement Coordinator and	-	Accuracy of Assessm		F 64	1		5/16/18
		The assessment must resident's status. This REQUIREMENT by: Based on staff interv facility failed to docur Level II determination (Resident #10 and #4 the correct discharge residents (Resident # Set (MDS) assessme 1. Resident #10 was 02/22/18 with diagnos failure, dependence of dementia, schizophre to known physiologic depression, and extra disorder. Review of the Admiss Resident #10 dated 0 Resident #10 had set never or rarely under dependent on staff fo did not reflect a PASF status. Review of the North 0 Health and Human S	st accurately reflect the T is not met as evidenced riews and record review the ment the correct PASRR in for 2 of 2 residents 14) and failed to document destination for 1 of 3 155) whose Minimum Data ents were reviewed. readmitted to the facility on ses that included respiratory on ventilator, tracheostomy, enia, catatonic disorder due al condition, major apyramidal and movement sion MDS assessment for 03/01/18 documented that verely impaired cognition, stood, and was totally or all care. The assessment RR Level II determination Carolina Department of ervices, Division of Medical		 Minimum Data Set for Resident#10, Resident #44,on 05/03/2018. The modification for Resident# 55 include changing A1500. 1510 and A2100 we modified to reflect the correction to Discharge location coding and PASR levels. Clinical Reimbursement Coordina (CRC) completed 100% audit on 5/9/ of Minimum Data Set for last 90 days 2/20/2018- 5/1/2018 for those resided who discharged from facility and the destination. No other residents were identified with incorrect coding. Clini Reimbursement Coordinator conduct 100% audit of resident with PASRR I II on 5/3/2018 Residents identified wi incorrect PASRR levels were modifie 5/3/2018 by the Clinical Reimbursem Coordinator conducted a 100% audit residents PASRR for accuracy. Regional Clinical Reimbursement Coordinator provided re-education to 	ere R tors 2018 5 nts cal evel th d on ent of all the	
BORAIONI DINECTORS ON I NOVIDENSOI I EIENNEI NESENIATIVE SISIANONE	ABORATORY		· · · · · · · · · · · · · · · · · · ·	RE	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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345409 B. WING 05/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **310 E WARDELL DRIVE** PEMBROKE CENTER PEMBROKE, NC 28372 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 1 F 641 02/19/18 determined that Resident #10 had a the interdisciplinary team. including CED, PASRR Level II determination, #2018050347B. ADON, Social Worker, Register Dietitian, Activities Director, on 5/10/2018 on coding Resident #44 was admitted to the facility on MDS section A1200 coding and coding 07/20/17 with diagnosis that included anxiety, PASRR A1500, A1510. The major depression, bipolar disorder, and end stage Reimbursement Coordinator and the renal failure requiring hemodialysis. Physician interdisciplinary team, including ADON, orders included Elavil, Celexa, Xanax, and Activity Director, Social Worker, Register hemodialysis 3 times a week. Dietitian will review Minimum Data Set for accuracy prior to transmission each week Review of the guarterly MDS assessment for on 100% of residents for 2 weeks, then Resident #44 dated 04/10/18 did not reflect a 50% of residents for 2 weeks, then 25% PASRR Level II determination status. of residents for 2 weeks and 10% of residents quarterly thereafter. Review of the North Carolina Department of Health and Human Services. Division of Medical 4. The center Clinical Reimbursement Coordinator will present the results of the Assistance Level II Evaluation Report dated 02/09/18 determined that Resident #44 had a audit for accuracy for the entire Minimum PASRR Level II determination, #2018040273B. Data Set that was completed prior to submission monthly to the Performance In an interview with the Social Worker on Improvement meeting for 3 months then 05/03/18 at 10:05 AM she said that Level II quarterly. PASRR information was communicated in the morning meeting and in the daily clinical meeting. She said every resident who had a diagnosis or who were on psychotropic medications were referred to the state on admission for PASRR review and evaluation. She said she did not complete Section A of the MDS and did not know why Resident #10 and Resident #44 had not been coded correctly with a PASRR Level II determination. In an interview with the MDS nurse on 05/03/18 at 10:10 AM she stated that Section A of the last assessment for Resident #10 was completed by herself. She stated on review of the assessment that she had not indicated in the assessment that Resident #10 had a PASRR level II determination.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/15/2018

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/15/2018 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345409	B. WING		_		C 03/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PEMBRO	E CENTER			310 E WARDELL DRIVE PEMBROKE, NC 28372	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	been done by the faci who had not coded the reflect that Resident # determination. She st the admissions depart department when a ref II determination. She took place in the more the daily clinical meet not know how these of and would complete re both showing that the Level II PASRR detern In an interview with the at 10:20 am she repor PASRR level II detern MDS to be coded acc 2. Resident #55 was 03/11/18. The residen included diabetes, per and atrial fibrillation. The resident's 03/18/7 set (MDS) documenter moderately impaired, of a verbal and physic directed toward others required extensive as mobility/dressing/toile was dependent on sta always continent of bo was stable, he had no discharge planning wa resident to return to the	tion A of the last d for Resident #44 had lity MDS Nurse Consultant e assessment correctly to 44 had a PASRR Level II tated that MDS was told by tment or the social work esident had a PASRR Level said the communication hing stand up meeting or at ing. She stated that she did leterminations got missed nodified assessments for Resident #10 and #44 had minations. e Administrator on 05/03/18 rted that if a resident had a hination she expected the ordingly. admitted to the facility on ht's documented diagnoses ripheral vascular disease, 18 admission minimum data ed his cognition was he exhibited behaviors not cal nature which were not s, he rejected care, he sistance from staff with bed ting/hygiene/transfers, he aff for bathing, he was owel and bladder, his weight o pressure ulcers, and active as already occurring for the he community.	F 64	1			
	On 03/21/18 "Resider	nt/patient has potential for					

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 06/15/2018 1 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345409	B. WING		_	(05/) 03/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
PEMBRO	KE CENTER			10 E WARDELL DRIVE PEMBROKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	discharge, or is expect related to admission f was identified as a pro- plan. Interventions for "Evaluate discharge p consideration care pla cognitive skills, function assistive devices. Ma community-based age services communication needs and barriers to A 03/29/18 Social Ser Discharge Assessment from acute hospital. For home today. Resider of home health agenon home health eval(uation). Resider Resident was transpor family. Resident has previous stay." This a the facility's Social Wor A 03/30/18 12:30 PM "Resident discharged (wheelchair)Accommodesignation). Received received discharge (p No distress or complar ready to go home." Resident #55's 03/30/ Anticipated MDS asseresident had a planner was admitted to the fac on 03/11/18, and the fac	eted to be discharged or skilled short-term stay" oblem in the resident's care or this problem included, blanning needs taking into ans, resident/patient goals, onal mobility and need for ake referrals to encies, providers, and ng the residents/patients care." vices Assessment: nt documented, "Entered tesident d/c (discharged) it will be followed by (name y). Resident d/c home with on) and therapy it d/c home with hardscripts. rted from facility to home by equipment at home from assessment was signed by orker on 03/30/18. progress note documented, from facility to home via w/c panied by (family member ed all scheduled meds. Also rescriptions) and directions. ints voiced. Verbalized was	F 641				

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		MEDICAID SERVICES	(X2) MUI TIPI F	CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	· · /	IPLETED	
						С
		345409	B. WING		0	5/03/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEMBRO	KE CENTER			10 E WARDELL DRIVE EMBROKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	e 4	F 641			
	-	5 PM the MDS Coordinator				
		verbal notification from the				
		er when a resident was going				
		he reported the social worker e date and destination. She				
	1 .	sidents were discharged to				
		pleted a return anticipated				
		en they went home she				
		ot anticipated assessment.				
	She stated resident	-				
		scussed in daily morning nd in weekly utilization				
		neetings. According to the				
		ne remembered discussion				
	about Resident #55					
		nd had also talked to the				
		on the day he was getting ed home. She reported				
		e resident's discharge				
		'hospital" was a data entry				
	error. She commen					
		dent's discharge destination				
	as "home".					
	On 05/03/18 at 12:1	1 PM the Assistant Director of				
		Director of Nursing) stated				
		that MDS information be				
		ore being submitted. She				
		pordinator should have				
		cy of her assessment before				
F 761	transmitting it. Label/Store Drugs a	nd Biologicals	F 761			5/16/18
SS=D	CFR(s): 483.45(g)(h					0,10,10
		of Drugs and Biologicals				
	Drugs and biological	s used in the facility must be				
	labeled in accordance	e with currently accented				
	professional principle					

Facility ID: 923393

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	06/15/2018 APPROVED		
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345409	B. WING			05/	C 03/2018		
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	, ZIP CODE				
PEMBROK	E CENTER		-	10 E WARDELL DRIVE EMBROKE, NC 28372					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE		
F 761	§483.45(h)(1) In acco Federal laws, the facil biologicals in locked of temperature controls, personnel to have acco §483.45(h)(2) The fac locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 ar abuse, except when the package drug distribut quantity stored is mini- be readily detected. This REQUIREMENT by: Based on observation interviews the facility for at recommended temp medication refrigerato Findings included: Review of the Pembro	y and cautionary expiration date when f Drugs and Biologicals rdance with State and ity must store all drugs and compartments under proper and permit only authorized cess to the keys. illity must provide separately offixed compartments for drugs listed in Schedule II of rug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the mal and a missing dose can is not met as evidenced h, record review and staff failed to store medications peratures for 1 of 2 rs.	F 761	 Pharmacy and Med called Medication were refrigerator and destroy 5/1/2018. All destroyer re-ordered from Pharm Pharmacist and Medic Recommended refrige every shift for to ensur consistent. All resident have the 	dical Director were e removed from yed per policy or ed medications we hacy at facility co cal Director erator be check re temperatures a	n ere st.			
	Administration literatu the product labels from	States Food and Drug re revealed "According to n all three U.S. insulin commended that insulin be		 affected by this deficie 3. All Nurses were in- medication storage po Consultant Pharmacis 	serviced on licy and procedu	re.			

Facility ID: 923393

If continuation sheet Page 6 of 9

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345409 B. WING 05/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **310 E WARDELL DRIVE** PEMBROKE CENTER PEMBROKE, NC 28372 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 761 Continued From page 6 F 761 stored in a refrigerator at approximately 36°F to temperature noted at time of findings. A 46°F. Avoid freezing the insulin. Do not use new temperature log was created, temperatures will be checked every shift x insulin that has been frozen. 4 weeks and then twice daily. Review of the Prolia Storage Temperatures Temperatures logs will monitored by DON showed Prolia should be. "stored at 35-46 or her designee daily x 2 weeks and then degrees", and to "not freeze". monthly. Review of the Promethazine Storage 4. The DON will present the results of the Temperatures showed Promethazine should be, audits for completed and temperature "stored at 35-46 degrees", and to "not freeze". compliance to the Performance Improvement meeting for 3 months and Review of the undated Medication and Vaccine then quarterly. Refrigerator/Freezer Temperatures Storage Policy revealed, "Refrigerators and freezers used to store medications and vaccines will operate within acceptable temperature range and will be checked twice a day for proper temperatures. The acceptable refrigerator temperature range for medication and vacccine storage is 36 F. to 46 F." In an observation on 05/01/18 at 4:17 PM the thermometer in the Long Hall medication refrigerator read 28 degrees F. The medication refrigerator contained multiple Lantus, injectable pens, multiple vials of different insulins (Novolog, Lantus, and Humalog), a vial of Prolia, and multiple Promethazine rectal suppositories. In a telephone interview on 05/01/18 at 5:21 PM the Facility's Consultant Pharmacist explained to the Administrator and the Assistant Director of Nursing (ADON) that the April/2018 Long Hall medication refrigerator temperatures should have been kept between 36 degrees F. and 46 degrees F., and if it was not, the medications stored in it needed to be replaced.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923393

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PRINTED: 06/15/2018

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION UMBER:			CONSTRUCTION		E SURVEY IPLETED	
		345409	B. WING			C
	ROVIDER OR SUPPLIER	343403		REET ADDRESS, CITY, STATE, ZIP COD		5/03/2018
	KE CENTER		31	0 E WARDELL DRIVE EMBROKE, NC 28372	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 761	10:30 AM with the AD medication refrigerato degree F. The ADON temperature should h degrees F. and 46 de ADON also stated that medication refrigerato through April 30 were F. to 34 degrees F. T responsibility of the 1 medication refrigerato stated if temperature F. or above 46 degree notify maintenance de notify manager, and t hour. And if temperatie below 36 degree F. o initiate product removie which was not done. In an interview on 05/ Nurse #1 stated the A medication refrigerato been kept between 30 degrees F., and was the responsibility of th medication refrigerato the nurses who signe on the Long Hall med temperature log from (which read from 26 of failed to follow the fac notify maintenance de	boorvation on 05/02/18 at OON revealed the Long Hall or temperature was 28 confirmed the refrigerator ave been between 36 grees F., and was not. The at 12 of the Long Hall or temperatures from April 1 e all reading from 26 degree he ADON stated it was the 1-7 nurses to record the or temperatures. The ADON registered below 36 degree e F., for staff to immediately epartment or Administrator, o retake temperature in 1 ture (after 1 hour) registers r above 46 degree F., to val/relocation procedure, 202/18 at 10:35 AM with April/2018 Long Hall or temperatures should have 6 degrees F. and 46 not. The nurse stated it was ne 11-7 nurses to record the or temperatures. The nurse d off on 12 of the 30 days	F 761			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/15/2018 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMP	SURVEY LETED
		345409	B. WING			_		C 03/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PEMBRO	KE CENTER				310 E WARDELL DRIVE PEMBROKE, NC 28372	!		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	April/2018 Long Hall r temperatures should l between 36 degrees I was not. In a telephone intervie the Corporate Consul had been in contact w ADON today and revie medication refrigerator as well as reviewed th stored in the refrigera the ADON that 32 deg freezing. She indicate kept between 36-46 d Pharmacist stated med frozen should not be of Pharmacist stated the the Long Hall medicated discarded and replaced Pharmacist stated she Adverse Drug Reaction the Long Hall refrigera 2018 not being within degrees F. In an interview on 05/ Administrator stated t medication refrigerator	medication refrigerator have been kept consistently F. and 46 degrees F., and ew on 05/2/18 at 11:00 AM ltant Pharmacist stated she with the Administrator and iewed with her the Long Hall or April 2018 temperatures he medications that were itor. She indicated she told grees was considered ed medications should be degrees. The Consultant edications that had been used. The Consultant at all medications stored in tion refrigerator were ed. The Consultant e was not aware of any ons (ADRs) as a result of ator temperatures for April 36 degrees F. and 46 (2/18 at 11:15 AM the the April/2018 Long Hall or temperatures should have y between 36 degrees F.	F	761				

Facility ID: 923393

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