DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING ______ B. WING ______	C 10/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey and Complaint Investigation were conducted on-site on 10/06/2020 and continued remotely through 10/12/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# OP5T11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 10/12/20. The facility was not found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event # OP5T11	F 000		
F 885 SS=D	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the	F 885		11/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/20/2020

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.

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F 885	Continued From page 1 facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to inform resident representatives and families by 5:00 PM the next calendar day following the occurrence of confirmed staff COVID-19 infections on 09/26/20 for 3 of 55 staff reviewed for COVID-19 reporting. Findings included: Review of the facility COVID-19 testing log revealed 3 staff tested positive on 09/26/20. An interview with the Administrator on 10/08/20 at 4:15 PM revealed the 3 staff who tested positive for COVID-19 on 09/26/20 were notified of positive COVID-19 status via telephone as soon as the positive results were received. The Administrator stated she did not think about notifying residents or residents' responsible parties of the staff who tested positive on 09/26/20, because they were notified weekly via phone calls by the department managers and documented in the residents' medical record regarding the facility having positive COVID-19 infections. The Administrator confirmed she was unaware the facility was required to report subsequent confirmed COVID-19 cases, so the facility did not contact families and/or responsible parties of residents who were not COVID-19	F 885	1. Corrective Action In-servicing was conducted with our department managers who are responsible for resident rounds and notification of our residents in person and to also make phone calls to the resident representatives and families by 5:00pm the next calendar day following the occurrence of a single confirmed COVID-19 infection or three or more residents or staff with new onset respiratory symptoms that occurred within 72 hours of each other. 2. Others having the potential to be affected All residents have the potential to be affected by the alleged deficient practice. There have been no residents or staff members who have tested positive for Covid-19 since 10/08/2020. 3. Measures of Systemic Changes The Department Managers will notify the resident and make phone calls to their respective representative or family member by 5:00pm the next calendar day following the occurrence of a single	

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F 885	Continued From page 2 positive on 09/26/20.	F 885	confirmed COVID-19 infection or of three or more residents or staff with new onset respiratory symptoms that occurred within 72 hours of each other. Each Department Manager will document in Point Click Care under Notes in the Clinical record the resident, their representative or family member that was notified and the reason for the notification. 4. Monitoring of Corrective Action The Center Executive Director or designee will audit 10 resident charts each week for the proper documentation regarding notification whenever the center has a new positive COVID-19 case or when there are three cases of new onset respiratory symptoms of residents or staff. These audits will be performed for 4 weeks then random audits will be completed weekly for 2 weeks. The Center Executive Director will bring the audits to the facility's QAPI committee meeting monthly X 3 months to ensure continued compliance.	