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 05/31/2024

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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 5/21/24 through 5/23/24. Additional information was obtained remotely on 5/24/24 and onsite validation of the immediate jeopardy removal plan was conducted on 5/28/24. Additional information was obtained remotely on 5/31/24. Therefore the survey exit date was changed to 5/31/24 Event ID# RD9W11. The following intakes were investigated: NC00217180, NC00217179, NC00215080, NC00215096, NC00213731, NC00217064, NC00217218, and NC00217790. Intakes NC00217064, NC00217128 and NC00217790 resulted in immediate jeopardy. 6 of the 13 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate jeopardy began on 5/15/24 and was removed 5/18/24. A partial extended survey was conducted. Substantial compliance was achieved on 5/31/24	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		

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

Electronically Signed | 06/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with residents, staff, medical doctor, nurse practitioners, and law enforcement, the facility failed to protect a female (who was deemed an incompetent person by the North Carolina Clerk of Court) resident's (Resident #1), right to be free from sexual abuse by a cognitively impaired male resident (Resident #2). On 05/15/24 Resident #1 was naked from the waist down in her bed when Nursing Assistant (NA) #1 observed Resident #2 in Resident #1's bed with his face between Resident #1's legs. Resident #1 was incapable of giving consent for Resident #2 to touch her. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause trauma. Additionally, the facility failed to protect Resident #2 from resident to resident physical abuse. Example #2 was cited at a scope and severity of D. This deficient practice affected 2 of 4 residents reviewed for abuse. The findings included:	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

1. Resident #1 was admitted to the facility on 02/02/22 with diagnoses which included, in part, dementia with other behavioral and psychotic disturbance, muscle weakness, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic pain syndrome, depression, anxiety disorder, muscular dystrophy, and bed confinement status.

A review of the State of North Carolina Letters of Appointment Guardian of the Person document revealed Resident #1 was deemed an incompetent person before the Clerk of The General Court of Justice Superior Court Division on 07/27/23.

A review of Resident #1's annual Minimum Data Set (MDS), dated 01/24/24, revealed that Resident #1 was severely cognitively impaired.

A review of Resident #1's Care Plan, last updated 02/07/24, revealed she exhibits or has the potential to demonstrate verbal and physical behaviors related to cognitive loss/dementia and indicated she preferred to wear facility gowns versus her own clothing and had tendencies to expose herself while lying in her bed without privacy precautions. The Care Plan indicated she had a Brief Interview for Mental Status (BIMS) score of 3 and noted it fluctuated at times. The Care Plan specified Resident #1 had impaired/decline in cognitive function or impaired thought processes related to vascular dementia and acute encephalopathy and exhibits or is at risk for alterations in functional mobility related to cerebrovascular vascular accident (stroke) with left-sided flaccid hemiplegia. The Care Plan indicated Resident #1 met Preadmission

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F 600	Continued From page 3	F 600		

Screening and Resident Review (PASRR) II Level of determination secondary to serious mental illness.

A review of Resident #1's quarterly MDS, dated 03/28/24, revealed that Resident #1 was cognitively intact, had the ability to make herself understood, had the ability to understand others, and had no behaviors. The MDS indicated that Resident #1 was dependent on staff for oral hygiene, toileting hygiene, bathing, upper and lower body dressing and personal hygiene.

Resident #2 was admitted to the facility on 03/02/22 with diagnoses which included dementia with other behavioral disturbances, cognitive communication deficit, mental disorder not otherwise specified, depression, anxiety disorder, and muscle weakness.

A review of Resident #2's quarterly MDS, dated 03/14/24, indicated that Resident #2 was moderately cognitively impaired with clear speech and the ability to make himself understood and to understand others. The MDS indicated Resident #2 had no behaviors and required the extensive assistance of one staff for bed mobility and transfers, had no impairment with his upper and lower extremities, and used a wheelchair as a mobility device.

A review of Resident #2's Care Plan, last updated on 03/15/24, revealed Resident #2 had the tendency to exhibit sexually inappropriate behaviors related to cognitive loss and dementia (initiated on 01/11/23), and had impaired and/or declined cognitive function or impaired thought processes related to dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 4	F 600		

An interview was conducted with Resident #3 on 05/23/24 at 8:15 a.m. Resident #3 was assessed as severely cognitively impaired on 02/27/24. Resident #3 asked if this interview was about the incident involving her roommate (Resident #1) and Resident #2 that had occurred a few nights ago or the one "a while back". When asked to explain, she said one weekend not too long ago (referring to the 05/11/24 incident), she said she had left her room and when she returned, she saw Resident #2 trying to get in the bed with Resident #1. She said she immediately left the room to find the nurse (Nurse # 1) and report him to her. Resident #3 said the nurse came to the room and threatened to call the law if he would not leave the room. Resident #3 said Resident #2 was always in her & Resident #1's room, day or night, because Resident #1 always wanted him to bring her a soda. She said as far as she knew, the two of them never had a sexual relationship but they did have a friendship and he spent a lot of time in their room bringing her sodas and talking to her.

A review of Resident #2's Progress Notes revealed he had been discovered by Nurse #1 on 05/11/24 entering a female resident's room and attempting to get in the bed with her.

An interview was conducted with Nurse #1 on 05/22/24 at 1:15 p.m. Nurse #1 indicated on Saturday, 05/11/24, around 1:00 p.m. - 2:00 p.m., Resident #3 was observed standing in the doorway to her and Resident #1's room and called for the nurse. Nurse #1 stated she went to the room and observed Resident #2 attempting to get into Resident #1's bed. Nurse #1 stated she had never known Resident #2 to display any inappropriate sexual behaviors with Resident #1

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	345409	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 5	F 600		

or any other resident. She explained that Resident #1 and Resident #2 have always had a friendship and he often brought her sodas; however, on that day, she observed Resident #2 to have placed his wheelchair beside Resident #1's bed and had one of his knees on the side of her bed as if he was trying to climb into the bed with her. Nurse #1 stated Resident #1 told her, "he's not doing anything" and that Resident #2 did not say anything. Nurse #1 stated she then removed Resident #2 from the room, returned him to his room, and put him into his bed. Nurse #1 explained she called the Director of Nursing (DON) to get the telephone number of the new Assistant Director of Nursing (ADON) who was their on-call admin that day. She further explained she informed the DON of the incident who instructed her to call the ADON. She did so and was told by the ADON to document the incident and because she had already removed Resident #2 from Resident #1's room, there had been no further instructions.

An interview was conducted with the ADON on 05/22/24 at 1:50 p.m. The ADON explained she had received a phone call from Nurse #1 on 05/11/24 about Resident #2 attempting to get in bed with Resident #1. The ADON further explained, stating that because Nurse #1 had already removed Resident #2 from Resident #1's room and had placed him in his bed, she said she instructed the nurse to continue to monitor. The ADON stated she failed herself in that she had not asked the nurse if Resident #1 was in her bed at the time Resident #2 was attempting to get in the bed as she assumed he was just trying to get into the bed. When asked if this incident had been discussed with the Interdisciplinary Team during their Monday morning meeting, she

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	345409	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 600	Continued From page 6	F 600		

indicated it may have been since it had been a change in Resident #2's condition, however she did not have any notes from that particular meeting.

Review of the facility's Initial Allegation Report, completed by Nurse #3 on 05/15/24, revealed an allegation of resident abuse on 05/15/24. The facility became aware of this allegation on 05/15/24 at 4:30 a.m. The allegation stated that a male resident (Resident #2) was found in a female resident's (Resident #1) room and that the male resident was noted to be performing oral sex on the female resident. The report indicated the facility reported the incident to law enforcement on 05/15/24 and to the State agency on 05/15/24.

The witness statement from NA #1 was reviewed. It read, " ...Patient [Resident #2] was addressed several times from getting in and out of bed. Patient was then placed up front to desk. Patient stated he was ready to go to bed. Patient was placed in bed. Patient was watched for 20 minutes and I started my rounds. I heard bell ringing and step into hall. I went to answer call light and saw [Resident #2] with his face between [Resident #1's] legs with her diaper off. Nurse was notified ASAP [as soon as possible]. Nurse responded ASAP. [Resident #1] stated that nothing happened. I saw [Resident #2] with his mouth on [Resident #1's] private part."

An interview was conducted with NA #1 on 05/21/24 at 12:13 p.m. NA#1 confirmed she worked the 11:00 p.m. to 7:00 a.m. shift that began on 05/14/24 and ended on 05/15/24 and had been assigned to care for both Resident #1 and Resident #2 during her shift. NA #1

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 05/31/2024

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PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 600	Continued From page 7	F 600		

explained Resident #1 was alert and able to make her needs known and required the extensive assistance of staff to being fully dependent on staff for her care needs. She explained that Resident #1 frequently removed her adult diaper and hospital gown so to find her in a stage of undress was not unusual for her. NA #1 explained Resident #2 had never displayed inappropriate sexual behaviors and admitted that he was known for frequent masturbation, however that act was always performed when he was in his own room. She stated that she had never known Resident #2 to make inappropriate sexual remarks or display inappropriate sexual behaviors towards other residents or staff. NA #1 stated that the rooms of each resident, on the morning of the incident, were located on opposite sides of the same hall however not quite directly across from each other. NA #1 explained that Resident #2 had been up and down all night and had required frequent redirection that night, which had been unusual for him as he typically stayed in his bed, in his room, at night. NA #1 stated she was not sure what had been going on with Resident #2 that particular night, but because he had been restless, she had given him a shower and placed him at the nurses' station in his wheelchair. She explained that he sat at the nurses' station for a couple of hours while she continued to make rounds on her other residents. She stated she had noticed Medication Aide (MA) #1 had taken him back to his room because he had wanted to lie down and stated she continued making rounds. Around 3:30 a.m. - 4:00 a.m. (05/15/24), she noticed the call light for Resident #1's room had come on and she went to the room to respond to it. Upon arriving to the room, the door to the room was shut and she had not been able to open it fully as Resident #2's wheelchair

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F 600	Continued From page 8	F 600		

was blocking the door from opening all the way. NA #1 explained she was able to push open the door enough so as to allow her head into the room and stated when she looked in, she noticed Resident #2's wheelchair was positioned near the foot of Resident #1's bed (with the wheelchair facing the head of Resident #1's bed), between the wall and the left side of Resident #1's bed however it blocked the door to the room fully opening. She stated she observed Resident #2's right foot on the floor and his left leg and upper torso was in the bed with Resident #1, with his face between Resident #1's legs and his mouth on Resident #1's vagina. She noted that he was dressed in a t-shirt and pajama bottoms while Resident #1 was observed in a hospital gown which had been pulled off one of her shoulders and the bed covers were pulled up to her chest but pulled away from the lower half of Resident #1's body leaving her exposed from the waist down. She stated Resident #1's adult diaper had been taken off and was noticed on the floor beside the bed. NA #1 indicated Resident #1's breasts were not exposed. NA #1 explained she and Resident #1 made eye contact but Resident #1 did not say anything at that time. She stated Resident #2 seemed unaware he was being observed. NA #1 stated she asked them, "what are y'all doing?" at which time Resident #2 became aware of her presence and looked at her but did not say anything. NA #1 stated she then took a step back, away from the doorway but still in sight of the residents, and immediately called for Nurse #4 who had been standing in an area by the front of the nurses' station. NA #1 stated Nurse #4 immediately came to the room. NA #1 heard Resident #1 tell the nurse that "nothing happened."

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	345409	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 600	Continued From page 9	F 600		

The witness statement from Nurse #4 was reviewed. It read, "[Resident #2] has made multiple attempts entering [Resident #2's] room. He was put to bed multiple times with himself transferring back the bed and attempting to enter her room again. He sat with us at the nurses' station for a while until he stated he was ready to lay down. After 20 minutes of no signs trying to get up again, me and the CNA [certified nursing assistant] [NA #1] was doing her rounds. She went into [Resident #2's] room to do care and found [Resident #1] with his head between her legs performing oral sex. She immediately informed me and resident [Resident #2] was removed from room. Unit Manager was called. DON [director of nursing] was called. Administrator was called with no answers. I then called [name of an Administrator from a sister facility who was assisting the facility while the facility's Administrator was out on leave] for further instructions. He directed me to call both resident's families and ask if they feel they are capable of making decisions. Placed [Resident #2] on 1:1 supervision, perform skin check on female resident. I got in contact with [Resident #2's] RP [responsible party], left a voicemail for [Resident #1's] RP to call the facility back at her earliest convenience. Got statements from all involved. Female stated nothing happened, male could not give coherent statement."

An interview was conducted with Nurse #4 on 05/21/24 at 3:47 p.m. Nurse #4 confirmed she worked on 05/14/24 from 7:00 p.m. until 7:00 a.m. (05/15/24) and had been assigned to care for Resident #1 and Resident #2. She explained she had noticed Resident #2 was awake, in his wheelchair, and that he kept trying to enter Resident #1's room and that he had to be

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	345409	A. BUILDING _____ B. WING _____	C 05/31/2024

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PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

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F 600	Continued From page 10	F 600		

frequently redirected. She said this was abnormal behavior for him; around 12:30 a.m. - 1:00 a.m. (05/15/24), he had been brought to the nurses' station where he stayed for approximately an hour. She stated around 3:30 a.m., the resident started nodding off, so he was brought to his room, assisted back into his bed and that once he started to fall asleep, she left. The nurse said around 15 minutes later, NA #1 informed her that Resident #2 was in Resident #1's bed and stated she immediately went to the room but once there, she could not fully open the door as his wheelchair was blocking it from inside the room. Since he was already back in his wheelchair, she pushed open the door wide enough for her to "shimmy" her way in there and immediately removed him from the room. Because of what NA #1 had told her, she returned to Resident #1's room and performed a skin assessment which included her perineal area (the area between the anus and vulva in females) which did not reveal any signs of trauma. After that, Nurse #4 stated she began making phone calls to the administrative staff which included the Administrator, the DON and the Unit Manager. When she did not get an answer, Nurse #4 called the Administrator from a sister facility (who had been assisting their facility during the absence of the facility's Administrator) who instructed her on what the next steps would be to begin an investigation of the incident. She stated she called the Responsible Party (RP) for Resident #2 and spoke with her. She stated she then called the guardian of Resident #1 (as she is a ward of the State) and left a message for her to return the call. Nurse #4 stated the guardian returned her call while and explained that Resident #1 was not able to give consent for a sexual act. Nurse #4 stated after that, the Unit Manager (Nurse #2)

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 11	F 600		

had arrived and had been the one to call local law enforcement who came to the facility and interviewed the staff. Nurse #4 stated she provided the police officer a copy of the statements she had taken from Resident #1 and Resident #2. Nurse #4 stated Medication Aide (MA) #1 witnessed her conversations with the Resident #2's RP and with Resident #1's guardian.

An interview was conducted with MA #1 on 05/22/24 at 8:49 a.m. MA #1 confirmed she worked on 05/14/24 from 7:00 p.m. until 7:00 a.m. She stated she had worked at the facility for as long as both residents had resided there and had never known Resident #2 to display any inappropriate sexual behaviors before. She also said it was the first time that she could recall seeing Resident #2 up in the middle of the night. MA #1 explained she had been charting at the desk at the nurses' station when she observed Resident #2 going into Resident #1's room, estimating the time to be before 4:00 a.m. but was unsure of the exact time. MA #1 further explained she took Resident #2 out of Resident #1's room and brought him to the nurses' station where he sat for approximately 15-20 minutes and then he was brought to his room. She stated after another 15-20 minutes or so, the call light for Resident #1's room came on, explaining it had been Resident #1's roommate (Resident #3) who had pressed the call light. MA #1 said she saw NA #1 go to the room to respond to the light and then heard NA #1 yell for Nurse #4 to go to the room. MA #1 said when NA #1 returned to the nurses' station, she described to her what she had witnessed in the room - that Resident #2 was in bed with Resident #1 and had his head between her legs. MA #1 clarified that she had

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 05/31/2024

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
F 600	Continued From page 12	F 600		

not written a statement about the incident as she did not witness anything herself, however, she did witness the statements Nurse #4 had taken from the two resident's responsible parties.

An interview was conducted with Resident #3 on 05/23/24 at 8:15 a.m. Resident #3 said the other night (referring to the 05/15/24 incident), Resident #2 probably would not have come into the room if Resident #1 had not invited him in. She said she was awake and although the curtain between the two beds was pulled and she could not see anything, she could hear the two of them whispering back and forth. Resident #3 said she could not really hear what they were whispering about, but she was adamant that Resident #1 never hollered out while Resident #2 was in the room. She said she pushed the call light button so someone would come and get him out of her room at that time of morning.

An interview was conducted with Resident #1 on 05/21/24 at 11:10 a.m. She was observed sitting up in her bed and wearing a hospital gown. After introductions, Resident #1 asked, "is this about [Resident #2]?" and then, before any further conversation, Resident #1 said, "I told him not to ever come back in here because he tried to come get in the bed with me. I had to hit him on the side of his head, and I stopped him from trying to get in bed with me." When asked if she had invited Resident #2 into her bed, she stated she had not and remarked that he had tried to go up under the covers and touch her leg and repeated what she had said moments before. Resident #1 then became focused on various body aches and pains and wanted to see her nurse and did not want to discuss the incident any further, therefore, the interview was stopped at this time.

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 05/31/2024

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
F 600	Continued From page 13	F 600		

A second interview with Resident #1 was conducted on 05/21/24 at 1:42 p.m. during which she was more receptive to questions and conversation about the incident of 05/15/24. Resident #1 was adamant that Resident #2 did not sexually assault her and stated that he did try to touch her leg under her bed covers and wanted to talk with her however, she could not understand what he was saying and she had told him to get out of her room and to never come back. Resident #1 stated Resident #2 did not touch her vagina with his hands, mouth or tongue. She stated he would bring her red sodas and admitted he was not her friend nor was she afraid of him. Resident #1 acknowledged the fact that she prefers to wear hospital gowns and stated she frequently removes them because they are aggravating. She also said she has to wear an adult diaper however, the tabs come undone which is also aggravating, so she will take it off frequently. Resident #1 remarked that she did not want Resident #2 to get in trouble for trying to touch her and said, "what's done is done."

An interview with Resident #2 was conducted on 05/21/24 at 1:59 p.m. He was observed sitting in his wheelchair assisting the Activities Director who had been assigned to stay with him during his 1 on 1 observation that day. Resident #2 admitted that he and Resident #1 were friends and that he would occasionally buy her a red soda and bring it to her in her room. When asked, Resident #2 stated he did recall the 05/15/24 incident. He explained when he was in Resident #1's room, she encouraged him to perform oral sex on her when she pulled the covers back and had her legs open. Resident #2

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 05/31/2024

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
F 600	Continued From page 14	F 600		

stated he did not have intercourse with her and said that she was so nice that he had wanted to treat her like a girlfriend. He also stated that Resident #1 did not tell him to stop or get out of the room and that she did not hit him. He stated after the incident, he was moved to another room on the other side of the facility and that Resident #1 had been moved to another facility.

An interview was conducted with the Unit Manager (Nurse #2) on 05/22/24 at 9:11 a.m. She confirmed that she worked on 05/15/24 from 7:00 a.m. until 6:00 p.m. Nurse #2 stated she had been made aware of an incident involving Resident #1 and Resident #2 when Nurse #4 called her at home, prior to her arrival to the facility. She indicated that she had spoken with the Administrator from their sister facility who had given her instructions related to the investigation of this incident. She explained she had called the police around 7:00 a.m. and that they had come to the facility right away and interviewed staff, but she does not think they spoke with either resident. Nurse #2 further explained she had moved Resident #2 across the building to another room on 05/15/24 and that Resident #1 was moved to a private room close to the nurses' station on 05/16/24. Nurse #2 stated she had never known Resident #2 to exhibit any inappropriate sexual behaviors, but that he often bought sodas for Resident #1 as well as other residents. She stated she had never known Resident #1 to have inappropriate sexual behaviors but did recall a time in the past where she appeared to have a fond relationship with a male resident (who no longer resided in the facility). Nurse #2 explained Resident #1 did like to undress and would frequently remove her hospital gown and adult diaper. She said 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 _____	C 05/31/2024

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
F 600	Continued From page 15	F 600		

talked with Resident #1 on the day of the incident and denied anything of a sexual nature had taken place with Resident #2; she said Resident #1 told her that she told him to get out of her room after he tried to get into her bed that morning. When asked about the difference in Resident #1's Brief Interview for Mental Status (BIMS) assessment scores, Nurse #2 stated she had been completing the Brief Interview for Mental Status (BIMS) assessments since the facility did not have a social worker on staff until recently. She confirmed she completed the 03/28/24 assessment on Resident #1 (which resulted in a score of 13) but had not done the January 2024 assessment (which had a score of 3). Nurse #2 explained that because of the discrepancy between the two assessment scores in such a relatively short period of time (as well as Resident #1's other varied BIMS scores), she had repeated the March assessment with a second nurse present and the score remained 13; she said she completed another BIMS assessment on Resident #1 on 05/15/24 and her score was 12.

A recreation of the room Resident #1 resided in on 05/15/24 was conducted on 05/23/24 at 8:00 a.m. with NA #1 who witnessed the incident of 05/15/24. Resident #1 had resided with Resident #3 in a semi-private room. Resident #1's bed had been the A bed, which was the bed closest to the door. The A bed remained empty, and the facility had placed a mannequin in the bed so administration could re-create the scene from the incident the evening prior to this observation. At the time of this observation, the mannequin was still in place and according to NA #1, the room was set up just as it had been the morning of the incident. The door to the room was closed; the bed divider curtain was pulled between bed A 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 _____	C 05/31/2024

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
F 600	Continued From page 16	F 600		

bed B, a 4-drawer dresser was observed in the space between the wall and the left side of Resident #1's bed, and a wheelchair representing Resident #2's wheelchair had been placed at the foot of the bed, facing the head of the bed as it had been during the discovery of the incident. NA #1 demonstrated how she had only been able to lean into the room after pushing the door open approximately 12 inches (as measured by NA #2 with a tape measure as he was present during this room observation). The bed was in a low position, approximately 18 inches from the floor. The mannequin had been placed in the bed to represent Resident #1 and it was lying on its back with its legs spread open at the hips and bent at the knees. NA #1 described how she had observed the positions of both Resident #1 and Resident #2 and stated the light over the head of the bed illuminated the area well enough for her to visualize Resident #1's vagina and clearly see Resident #2 performing oral sex on Resident #1. Based on the surveyor's observation made during this reenactment, it was verified NA #1 would have been able to visualize the position and actions of the residents (Residents #1 and #2) as she described.

An interview was conducted with Resident #1's legal guardian on 05/22/24 at 10:39 a.m. The guardian explained she is Resident #1's Guardian Representative while the Director of the [name of] County Department of Social Services is the resident's guardian. The Guardian Representative explained she was informed of the 05/15/24 incident involving Resident #1 and Resident #2 on 05/15/24 and stated it was procedure for her to go to the facility and talk with Resident #1 after an allegation such as this. She spoke with Resident #1 at 1:22 p.m. on 05/15/24

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 05/31/2024

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
F 600	Continued From page 17	F 600		

and during her conversation with her, Resident #1 was adamant nothing happened, and that the resident told her that a man tried to get on the bed with her, that she slapped him on the side of his head and told him to get out. During her interview with Resident #1, she stated that she discussed consent with her and asked her what it meant to give consent. The Guardian Representative stated Resident #1 was able to give an accurate definition of consent. The Guardian Representative explained the resident told her she and Resident #2 were not in a relationship, however, they were friends and that he often brought her sodas and they would talk. She said the resident also told her that she and Resident #2 had never talked about sexual activity before and that he had never tried to get into her bed before. The Guardian Representative stated after a bit of talking with Resident #1 that the resident told her she was tired of talking about it and began to pretend cry and repeated "I told you, nothing happened." The Guardian Representative explained when she had talked with Nurse #4 earlier that day, she had informed the nurse that Resident #1 was not able to give consent; however, after interviewing Resident #1 herself, she felt that the resident was indeed able to give consent for a sexual act if she wanted that type of relationship. She explained in the past, Resident #1 had been deemed an incompetent adult by the Clerk of Court and said that she informed Nurse #4 of this during their phone conversation. However, after talking with Resident #1, she had been able to name all of her body parts, she knew what sexual activity was, and she knew what consent meant. The Guardian Representative stated that she believed a sexual act between Resident #1 and Resident #2 did occur and stated she felt that Resident #1

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 05/31/2024

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
F 600	Continued From page 18	F 600		

denied it because she was embarrassed and scared she might get in trouble.

A review of Resident #2's Nurse Practitioner (NP) progress note, dated 05/15/24, revealed he had been seen for inappropriate sexual behavior towards a female resident. The note indicated that Resident #2 was witnessed by staff members "in a female resident's room at his own will. Staff witnessed this resident giving oral sex to a female resident ...this resident was immediately removed from the female resident's room and a sitter was in place. During my assessment, [Resident #2] verbalized to me that he thought he and the female resident were in a relationship. He stated that he assumed this was his girlfriend because he takes her [soda] almost every day. He admitted that he rolled himself into her room. He stated, 'I put my mouth in her private area.' I asked [Resident #2] if she was in agreement. He said, 'Yes.' He said that was when staff caught him in her room ...I educated [Resident #2] that this type of behavior cannot occur in this environment. He was educated on the reason why a sitter was in place and why staff changed his room. He did understand ... Diagnosis, Assessment and Plan: Inappropriate behavior - sexual inappropriate behavior, including touching, towards a female resident; one-to-one staff at bedside; new room on a different wing ... Dementia with behavior problem - ...[name of psych nurse practitioner] made aware ...; I did report to unit coordinator that resident was able to recall and admit being in a female resident's room."

An interview was conducted with the Nurse Practitioner (NP) on 05/22/24 at 10:08 a.m. The NP stated she assessed both Resident #1 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 _____	C 05/31/2024

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
F 600	Continued From page 19	F 600		

Resident #2 on 05/15/24. She explained she did a head-to-toe assessment on Resident #1 (which included her external genitalia) and there were no signs of trauma. During her examination, she asked Resident #1 questions about the incident, trying to keep the conversation casual. She stated the resident was able to tell her that a bald-headed man in a wheelchair came into her room; she then asked the resident if she had invited him into her room and the resident said no, that he had come in on his own. The NP said she then asked her if the man had touched her and she said no, that he did not touch her or do anything to her. The NP said Resident #1 began to get anxious and she stopped the conversation. The NP clarified that she did not feel Resident #1 was able to consent to a sexual act due to her history with cerebrovascular accident (stroke), dementia, anxiety, depression and a scattered thought process. During her assessment with Resident #2, the NP explained she asked him open-ended questions. The NP stated Resident #2 recalled the police coming to the facility and that he had self-propelled himself into Resident #1's room (who he thought was his girlfriend) and said he put his mouth on her private area. The NP stated she asked Resident #2 if Resident #1 had been in agreement with what he did and said he said yes. The NP stated she explained to Resident #2 that type of behavior was not allowed and explained to him why he had been moved to another room across the building and also that he would have to have a sitter. The NP stated Resident #2 appeared to understand his actions and their consequences and had even asked if Resident #1 was in her "right mind." She stated she asked him if Resident #1 had invited him into her room and he told her that he went in on his own. The NP stated Resident #2 is cognitively

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 05/31/2024

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
F 600	Continued From page 20	F 600		

impaired and is alert and oriented to name and situation but has poor judgment. After completing assessments on both residents, the NP stated she referred both of them to the psychiatric nurse practitioner.

A review of Resident #2's psychiatric follow-up evaluation, conducted on 05/15/24 by a behavioral health nurse practitioner (NP), revealed he had been seen per staff request as staff reported an alleged sexual interaction between Resident #2 and Resident #1. When the NP asked Resident #2 about the interaction, the NP indicated in the progress note that Resident #2's responses were disorganized, and that conversation was difficult to follow. The NP planned to discontinue the 1 on 1 sitter and to monitor for changes in his mood and behaviors.

An interview was conducted with the psychiatric Nurse Practitioner (NP) on 05/22/24 at 12:18 p.m. The NP explained she had been made aware of the 05/15/24 incident between Resident #1 and Resident #2 and had assessed them both on 05/15/24. The NP explained that she follows Resident #1 for dementia, anxiety, depression, insomnia and medication management. She stated Resident #1 is normally alert and oriented to name only and sometimes place - depending on her agitation level as she is easily agitated. The NP stated Resident #1 told her that Resident #2 was trying to get into her bed and that she yelled at him, told him no, and told him to get out of her room. The NP stated she did not ask Resident #1 any specific questions based on what staff had told her but during their conversation, Resident #1 told her, "he didn't do anything, he never even touched my privates." The NP clarified that Resident #1 was not

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 05/31/2024

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
F 600	Continued From page 21	F 600		

capable of consenting to a sexual act although she is a higher-functioning dementia patient as compared to Resident #2. The NP explained that she follows Resident #2 for his dementia diagnosis and that he is alert and normally oriented to person. She stated Resident #2 is moderately cognitively impaired with some days being better than others. The NP explained when she saw Resident #2, his answers were nonsensical and the conversation with him was stopped. The NP explained she discontinued the 1 on 1 observation for Resident #2 because he had already been moved to a room on a different hall and had no history of inappropriate sexual behaviors.

A review of Resident #2's progress note by the facility's medical doctor (MD) on 05/17/24 indicated that he was seen for a suspected sexual encounter with another patient. "Apparently, this patient entered the room of another patient. The female patient denied any physical intimacy occurred. [Resident #2] has dementia and is not able to answer questions with any reliability. It is reported staff members witnessed the sexual encounter ... However, the patient [Resident #2] does not accurately recall the encounter. He did seem to believe he was in a relationship with the patient ... The patient has been gradually deteriorating to the point he requires assistance with his daily ADLs [activities of daily living] ... Physical Exam ...cognitively impaired. Not aware of date, time, location ... Diagnosis, Assessment and Plan ...Inappropriate behavior: followed by psych. His room has been moved to a distant location away from the female patient with whom he had an inappropriate encounter ..."

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 05/31/2024

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
F 600	Continued From page 22	F 600		

Nurse #4 spoke with Resident #1 on 05/15/24 and wrote her statement. The statement read, "Resident #1] states [Resident #2] kept entering her room and she kept saying 'leave and don't come back in here.' She states she told him 'no.'"

Nurse #4 spoke with Resident #2 on 05/15/24. The statement read, "Resident [Resident #2] was asked about the incident. He provided incoherent information about the situation."

Nurse #4 called the RP of Resident #2 on 05/15/24 and took her statement via phone call. The statement read, "[name of Resident #2's RP] stated she does not feel that resident [Resident #2] is mentally competent enough to be able to consent nor deny or make the decision rationally to have any kind of sexual contact."

Nurse #4 called the legal guardian of Resident #1 on 05/15/24 and took her statement via phone call. The statement read, "[Resident #1's] guardian stated she [Resident #1] is not competent or capable of making the decision to consent to sexual acts. She has been deemed as an incompetent adult by the Clerk of Court of [name of] County."

An interview was conducted with the Medical Doctor (MD) on 05/22/24 at 11:33 a.m. The MD stated the facility's staff had informed him of the incident involving Resident #1 and Resident #2 on 05/15/24. He explained he evaluated Resident #1 on 05/17/24 and while he did not perform a pelvic exam, he had been told one had been done by the Nurse Practitioner and there were no reports of trauma. He said during his exam, Resident #1 had answered questions appropriately and when he questioned her about

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 05/31/2024

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
F 600	Continued From page 23	F 600		

the incident, she told him that "nothing happened" despite the incident being witnessed by a staff member. The MD explained in regard to Resident #1 being able to consent to a sexual act, he would defer that question to the psychiatric provider; however, because Resident #1 is sticking to her statement that nothing happened (when it obviously did), he felt that she is probably able to consent to a sexual act because it takes more thought processes to keep up with a lie than not. He further explained that in people with dementia, they tend to "lose the lie" and she has not. In regard to Resident #2, the MD stated his ability to consent to sexual activity is questionable as he displays signs and symptoms of dementia periodically.

A review of the police report revealed local law enforcement had been contacted by the facility on 05/15/24 regarding a sexual assault. The police officer had been advised by the nurse at the facility that both residents were cognitively impaired due to dementia and that neither resident remembered the incident occurred. The report included that there were no bruises or marks on either resident at the time of the incident.

An interview was conducted with the lead Detective on the case on 05/23/24 at 8:52 a.m. The Detective stated that he had not officially been to the facility to begin an investigation. He explained that from a law enforcement standpoint, he did not think either Resident #1 or Resident #2 could be interviewed secondary to both residents having a diagnosis of dementia and explained he would have a hard time pressing criminal charges against Resident #2 because of the dementia diagnosis. The

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 05/31/2024

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
F 600	Continued From page 24	F 600		

Detective explained he would be discussing the case with the District Attorney and reviewing law books and cases to see if any other charges could be filed.

An interview was conducted with the Corporate Nurse Consultant and the corporate Market Clinical Advisor on 05/23/24 at 9:08 a.m. at the request of the Market Clinical Advisor. She explained that because of discrepancies noted during their investigation, they had asked NA #1 to recreate the incident in the original room of Resident #1 using a mannequin. After the recreation of the incident, another statement was written. The Market Clinical Advisor requested the State Agency to consider this new information.

A review of a statement, written on 05/22/24 and signed by NA #1 and other members of the facility's administrative team read, "[NA #1] was re-interviewed and asked to perform a return demonstration. A full body [mannequin] was placed in the bed and the Nursing Assistant was asked to position the [mannequin] in bed. The Nursing Assistant also positioned the bed, privacy curtain, and wheelchair as it appeared on the night in question. After positioning the wheelchair, she opened the door and placed her head in the door frame. The width measured approximately 6 to 6.5 inches, just enough room for her to place her head in the door frame. The Nursing Assistant positioned another employee in the position of the resident. Based on observation, the Nursing Assistant was unable to visualize the resident's private area and was only able to see a narrow view of the back of the male patient's head."

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 05/31/2024

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
F 600	Continued From page 25	F 600		

An interview was conducted with the Administrator on 05/23/24 at 12:43 p.m. The Administrator, when asked how this incident occurred, stated she did not think this incident could have been prevented. She explained, stating that Resident #1 and Resident #2 had a friendship and that Resident #2 often visited with Resident #1 in her room bringing her sodas but there had never been a history of any inappropriate sexual conduct between the two of them. The Administrator stated Resident #2 will remain on 1 on 1 observation 24 hours a day, 7 days a week. She further explained that psychiatric services will continue to follow Resident #2 and that they are working with his family seeking placement for him elsewhere, in a behavioral unit that will be better suited for his needs.

The Administrator was notified of Immediate Jeopardy on 05/23/24 at 9:48 a.m.

The facility provided the following corrective action plan with a completion date of 05/18/24.

Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:
--On May 15, 2024, the Certified Nursing Assistant promptly escorted Resident #2 from the room and 1:1 direct supervision was implemented immediately and is ongoing.
--A Licensed Nurse assessed the resident #1 on May 15, 2024, and no signs of trauma, discharge, or odor was noted in the perineum area. The assessment included an evaluation of the external vaginal and surrounding areas of the skin and clothing. The preliminary psychosocial assessment was performed by the licensed nurse

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 26	F 600		

and indicated no change in mood or demeanor during this assessment and examination.
--On May 15, 2024, the Licensed Nurse notified the Physician and Responsible Party/Legal Guardian of the allegation. No new orders were initiated.
--Director of Nursing initiated a room change for Resident #2 on May 15, 2024. Resident #2 was moved to a different unit.
--Director of Nursing initiated a room change for Resident #1 on May 16, 2024. Resident #1 was moved to a room next to the Nurses station.
--On May 15, 2024, the Certified Registered Nurse Practitioner assessed the Resident #1, and no new orders were initiated.
--The Director of Nursing reviewed and updated care plans for Resident #1 and Resident #2 on May 15, 2024.
--On May 15, 2024, the Psychiatric Mental Health Nurse Practitioner assessed Resident #1 and Resident #2 and no new orders were received.
--On May 15, 2024, the Nursing Home Administrator filed a self-report with the Health Care Personal Registry and initiated an investigation.
--On May 15, 2024, the Director of Nursing notified the Local Police Department and reported the allegation.
--On May 15, 2024, the Director of Nursing notified Adult Protective Services of the allegation.

Address how the facility will identify other residents having the potential to be affected by the deficient practice:
--On May 16, 2024, the Director of Nursing interviewed all alert and oriented residents deemed as interviewable to identify any concerns and examine feelings of safe

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 27	F 600		

interactions/encounters towards others. No issues were identified.
--Licensed Nurse conducted a skin assessment on residents deemed as non-interviewable on May 15, 2024, no findings were identified of injuries of unknown origin or suspicion of sexual abuse.
--On May 16, 2024, the Director of Nursing and the Unit Manager conducted an audit of other residents with a history of behaviors with specific emphasis on sexually inappropriate behaviors per the MDS to ensure a patient-centered behavior management treatment plan is in place. No issues were identified.
--The Director of Nursing reviewed accidents/incidents in the last 30 days from the Risk Management System on May 16, 2024, to identify residents involved in resident-to-resident altercations to validate appropriate interventions were initiated. No additional concerns were identified.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
--On May 15, 2024, the Nurse Practice Educator initiated 100% re-education with employees (full-time, part-time, contract) in all disciplines (Nursing, Therapy, Housekeeping, Dietary, Laundry, Activities, and Administration) on Abuse Prohibition policy and procedure, including but not limited to, the definition, types of Abuse (Physical, Mental/Emotional, Neglect, Sexual, and Financial), prevention and supervision, identification, reporting of abuse, and trauma. Training emphasized what is considered Sexual Abuse; i.e.: unwanted sexual contact and non-contact such as sexual harassment. Additionally, education emphasized immediately

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 28	F 600		

protecting the resident when abuse is identified and that anyone can be a perpetrator of abuse. The education also addressed sexual abuse as a non-consensual sexual contact of any type with a patient. It includes but is not limited to sexual harassment, sexual coercion, or sexual assault as defined in our abuse policy. Education was completed by May 17, 2024. Director of Nursing will ensure employees with scheduled time off, on leave of absence (FMLA), vacation, or as needed will be re-educated prior to returning to duty. New hires (full-time, part-time, contract) will be educated during the orientation process by the Nurse Practice Educator or Director of Nursing Services.
--Nurse Practice Educator initiated re-education on May 15, 2024, with Nursing employees on Behavior Management with emphasis on management of challenging behaviors, supervision, notification, documentation, and care plan development to promote safe, appropriate and patient-centered behavioral symptom management. Education was completed by May 17, 2024. Director of Nursing will ensure employees with scheduled time off, on leave of absence (FMLA), vacation, or as needed will be re-educated prior to returning to duty. New hires (full-time, part-time, contract) will be educated during the orientation process by the Nurse Practice Educator or Director of Nursing Services.
--The Nurse Practice Educator initiated re-educated on May 15, 2024, with Licensed Nurses on changes in condition with emphasis on changes that require immediate physician notification and documentation to identify any behavior changes. Additionally, re-education was completed with Certified Nursing Assistants on early identification of changes in condition 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 _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 29	F 600		

prompt notification of changes. Education was completed by May 17, 2024. The Director of Nursing will ensure employees with scheduled time off, on leave of absence/ (FMLA), vacation, or as needed staff will be re-educated prior to returning to duty. New hires (full-time, part-time, contract) will be educated during the orientation process by the Nurse Practice Educator or Director of Nursing Services. The Director of Nursing will track the education to ensure employees who have not received it will not take an assignment.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
--The Director of Nursing and/or designee will review and monitor the nursing progress notes, e-Interact (a form that is utilized to address a change in condition), and Stop and Watch alerts (a form that is utilized to alert the licensed nurse) during the morning Clinical Meeting to identify and address any residents with behaviors. Monitoring will be completed 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks with a completion date of August 12, 2024. The Director of Nursing, the Assistant Director of Nursing, Unit Manager, and the Nurse Practice Educator attend the Clinical Meeting.
--Nursing Home Administrator hosted an AD HOC Quality Assurance Performance Improvement meeting on May 15, 2024 in collaboration with the Medical Director. Those in attendance included the Director of Nursing, Assistant Director of Nursing, Unit Manager, Business Office Manager, Central Supply, and Maintenance Director.
--The Director of Nurses and/or designee will interview 10% of the resident population deemed

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 05/31/2024

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
F 600	Continued From page 30	F 600		

as interviewable weekly for four weeks, then bi-weekly for four weeks, then monthly for one month to ensure residents feel safe and verbalize no concerns with
resident to resident encounters/interactions.
--The Director of Nurses and/or designee will review 10 skin assessments of residents deemed non-interviewable for any injuries of unknown origin or suspicion of abuse weekly for four weeks, then bi-weekly for four weeks, then monthly for one month.
--The Director of Nurses and/or designee will randomly audit residents exhibiting sexually inappropriate behaviors weekly for 30 days, then bi-weekly for 30 days, and then monthly for 30 days to ensure a patient-centered behavior management treatment plan is in place.
--The Administrator or Director of Nursing or Designee will review and report results of the audits in the Quality Assurance Performance Improvement Committee meeting monthly for one quarter. Subsequent plans of corrections will be implemented as
necessary.

Person responsible for the plan: Nursing Home Administrator

Alleged immediate jeopardy removal date and corrective action completion date: 5/18/2024

Onsite validation of the correction action plan was completed. Interviews confirmed all staff in all of the facility's departments were educated on the facility's Abuse Prohibition policy and procedures, Behavioral Symptom Management and Behavior Rounds Best Practice, and Enhanced Patient Supervision: Continuous 1:1 (1 on 1). Review of audits and observation tools were conducted

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 31	F 600		

including a review of the Continuous 1 on 1 Supervision log book for Resident #2 which included notes of his activity, behavior, location, and initials of staff providing the 1 on 1 supervision which is documented every 30 minutes. The immediate jeopardy removal date and corrective action completion date was verified as 05/18/24.

2) Resident #4 was admitted into the facility 12/7/2020 with diagnoses of unspecified dementia, unspecified severity, with psychotic disturbance, generalized anxiety disorder, depressive episodes, and acquired absence of right leg above knee.

A review of Resident #4's quarterly Minimum Data Set dated 12/6/23 indicated that he was moderately cognitively impaired, had no behaviors, and no rejection of care.

A review Resident #4's comprehensive care plan revealed a focus created on 2/9/21 of resident/patient exhibits or has the potential to exhibit physical and verbal behaviors related to: unspecified dementia, unspecified severity, with psychotic disturbance. Interventions included evaluating the nature and circumstances (i.e., triggers) of physical behavior with resident and/or resident representative. Discuss findings with resident and family members/caregivers and adjust care delivery appropriately. Encourage the resident to seek staff support for distressed mood. Observe for non-verbal signs of physical aggression, e.g., rigid body position, clenched fists, etc. Remove the resident from the environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice. If the resident becomes

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 05/31/2024

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
F 600	Continued From page 32	F 600		

combative or resistive, postpone care/activity and allow time for him to regain composure.

Resident #2 was admitted into the facility on 3/2/22 with diagnoses of non-Alzheimer's dementia, anxiety and depression.

A review of Resident #2's annual Minimum Data Set dated 10/18/23 indicated that he was moderately cognitively impaired and had no behaviors or rejection of care.

A review of Resident #2's comprehensive care plan revealed a focus on Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: Sadness/depression with interventions of Provide resident/patient with opportunities for choice during care/activities to provide a sense of control and Social Service visits to provide support, as needed.

On 2/20/24 the facility submitted an initial allegation report related to Resident #4 and Resident #2 having an altercation when Resident #2 ran over Resident #4's foot while leaving an activity. Resident #4 then punched Resident #2 on the right side of his face near his nose resulting in a bruise. The residents were separated, and Resident #2 was sent to the emergency room for evaluation and Resident #4 refused to go for evaluation. The facility notified the resident representatives, medical director, adult protective services, and police.

A review of the hospital report dated 2/20/24 for Resident #2 indicated a computerized tomography revealed no intracranial or facial injuries or abnormalities and he returned with no new orders.

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 33	F 600		

The facility investigated, and a witness statement dated 2/20/24 was obtained from the Recreational Activity Assistant that stated Resident #2 had approached the Recreational Activity Assistant for a muffin. When he received his muffin, he proceeded to leave and accidentally bumped into Resident #4. Resident #4 then punched Resident #2, Resident #2 started to defend himself and the residents were separated. The Director of Nursing interviewed Resident #2 who stated that he had run into another resident and was going to apologize when Resident #4 hit him. The former Social Worker noted that Resident #2 was very apologetic.

An interview was conducted with Nurse #5 (who is normally scheduled on Resident #4's hall) on 5/22/24 at 9:00 AM revealed that Resident #4 was moody and if he refused something Nurse #5 would leave him alone at that time and would go back and try him again. He further revealed that he could usually tell what mood Resident #4 was in and adjusted what he needed to do to ensure that he did not escalate the behavior or situation.

An interview conducted on 5/22/24 at 11:00 AM with the Recreational Activity Assistant revealed that Resident #2 had attended a baking activity. When Resident #2 received his muffin, he attempted to turn his wheelchair to leave and bumped or ran over Resident #4's foot on accident. She stated that before she could get to the two residents Resident #4 had punched Resident #2 and Resident #2 had hit Resident #4 back. She stated that she called for help and separated the two residents.

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 34	F 600		

An interview was conducted on 5/22/24 at 11:30 AM with the Recreational Activity Director who sat with Resident #4 indicted that Resident #4 was normally a loner who did not like anyone in his personal space however once he felt his space was being invaded, he became hostile either verbally or physically towards the person. She further indicated that during the time she sat with him he was in his room watching television and she had no problems with him. She also indicated that if he had become aggressive that she would have given him space and talked calmly to him so she would not antagonize him more.

An interview conducted on 5/22/24 at 1:00 PM with Resident #4 indicated that he remembered the incident and stated that "that guy ran over my foot, and I hit him" he further indicated that he only had one foot left and he was going to protect it any way that he could. He denied that he had received any injury related to the altercation.

An interview conducted on 5/22/24 at 1:30 PM with Resident #2 revealed that he remembered the incident and that he had accidentally ran over another person's foot when he was turning his wheelchair to leave, and the other person hit him, so he hit him back. He further stated that he had not had any issues with the other person before or since that time.

An interview with the Administrator on 5/22/24 at 2:00 PM indicated that she was made aware of the incident and that the residents had been separated. She stated that Resident #4 was immediately put on one to one until psychiatric services saw him, both residents had skin checks completed, and Resident #2 was sent to the Emergency Room for evaluation, but Resident #4

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 05/31/2024

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
F 600	Continued From page 35	F 600		

refused to go to the Emergency Room for the evaluation stating that he was fine. The Administrator stated that Resident #2 returned from the Emergency Room with no new orders and noted that he had sustained no fractures but did have a bruise located by his nose. She further indicated that Psychiatric services saw Resident #4 the next day and removed him from one on one after she spoke to him and readjusted his medication.

The facility initiated a four-step plan of correction which included:
" On 2/20/24 Resident #4 and Resident #2 were both separated, and Resident #4 was placed on one-to-one supervision. As of 5/19/24 Resident #4 has been placed on one-to-one supervision indefinitely.
" The Abuse Prevention Coordinator was notified of the occurrence and a report was filed with the Department of Health and Human Services on 2/20/24.
" The administrator and or designee notified Adult Protective Services of the occurrence on 2/20/24.
" The Licensed Nurse assessed Resident #4 and Resident #2 on 2/20/24 and notified the Physician and responsible parties.
" The Social Service Director assessed Resident #4 on 2/20/24 and a referral for Psychiatric services was generated.
" Psychiatric Services evaluated Resident #4 on 2/21/24 and changed his medication.
" Psychiatric Services re-evaluated Resident #4 on 2/27/24 with no changes in orders.

How the facility identified other residents having the potential to be affected by the same deficient practice.

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 05/31/2024

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
F 600	Continued From page 36	F 600		

" A licensed nurse and/or designee conducted a 30 day look back of incident/accidents and no further resident to resident altercations and/or changes in behavior were noted as of 3/20/24.

The measures put into place or systemic changes made to ensure that the deficient practice will not occur was completed by:
" The Nurse Practice Educator and/or designee-initiated re-education with employees on the Abuse Prohibition policy with emphasis on strategies to reduce and/or prevent resident to resident altercations. This education was started on 2/20/24 and was completed on 2/22/24.
" Supervision by the Administrator and/or his designee during mealtimes to assist with the flow of traffic in and out of the dining area also started on 2/22/24.

" The Director of Nursing and or/designee will audit a sample of residents who exhibit identified behaviors of wandering, physical behaviors towards staff or others, and verbal behaviors towards staff or others, weekly for 30 days starting 2/20/24, then monthly for two months to ensure no other residents to resident altercations and ensure the plan of care was being followed to reduce behaviors.

" The Nursing Home Administrator and/or designee will review the results of the audit of any resident-to-resident altercation prior to 2/20/24 in the next Quality Assurance Performance Improvement meeting.

" The Administrator or Director of Nursing or Designee will review, and report results of the audits in the Quality Assurance Performance Committee meeting monthly for one quarter. If

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 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 600	Continued From page 37	F 600		

the audits reveal a potential or actual event related to resident to resident altercations subsequent plans of correction will be submitted as necessary. This will start with the next Quality Assurance Performance Committee meeting in March of 2024.

The plan of correction was verified on 5/23/24 by reviewing the one-on-one documentation for 2/20/24-2/21/24 and one-on-one documentation from 5/19/24 to 5/23/24. The Psychiatric notes dated 2/21/24 noted that the Psychiatric Nurse Practitioner had removed Resident #4 from one-on-one and had increased Resident #4's Zyprexa. Her note dated 2/27/24 was also reviewed and reflected no additional changes in his medication and noted no further behaviors. A review of the in-service Abuse and Neglect and Resident Rights conducted on 2/20/24 through 2/24/22 was reviewed to ensure 100% of the staff had attended and interviews were conducted with random staff to ensure education had been received and understood. A review of the Quality Assurance Performance Committee meeting minutes included the audits of resident behaviors and of the 30 day look back period for any resident to resident altercations. Observations during mealtimes during the survey dates for flow of traffic in and out of the dining area were completed and a review of the monitoring of sampled residents who exhibited behaviors was completed.

The validation verified the facility was back in compliance on 5/19/24.