STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345409	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pembroke Center	**310 E Wardell Drive , Pembroke, North Carolina, 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
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 05/19/26 through 05/21/26. Event ID# 232B74-H1. The following intakes were investigated: 3013348, 3011373, 2741572, and 2734495. 5 of the 5 complaint allegations did not result in deficiency.	F0000		06/08/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to obtain a physician's order for the initiation of oxygen therapy for 1 of 1 resident reviewed for respiratory services (Resident #1). Findings included: Resident #1 was readmitted to the facility on 5/5/26 with diagnoses that included chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues) and congestive heart failure. Review of the hospital discharge summary dated 5/5/26 revealed no order for nasal cannula oxygen upon Resident #1's return to the facility.	F0695	Corrective Action for the Affected Resident: The attending physician was contacted immediately to clarify the oxygen weaning order, including specific oxygen flow rates, target oxygen saturation parameters, monitoring requirements, and criteria for weaning on 5/20/2026 by Unit manager. On 5/20/2026 the Unit Manager entered the order into the medical record and licensed nursing staff were educated on the updated order. Resident #1 was assessed for respiratory stability and tolerance facility's Respiratory Therapist, on 5/20/2026. No issues were identified. Identification of Other Residents at Risk: On 5/20/2026 Facility's Respiratory Therapist, conducted an audit of all residents receiving oxygen therapy to ensure physician orders included clear parameters for oxygen administration and/or weaning. Any unclear or incomplete orders identified were clarified with the physician promptly. Systemic Changes to Prevent Recurrence: On 5/20/2026 the facility's Nurse Practice Educator, began re-educating all licensed nurses and Respiratory Therapists regarding requirements for complete and clearly defined oxygen therapy orders, including weaning parameters and physician clarification procedures. All newly hired licensed nurses including agency will receive the education in	06/11/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0695 SS = D	Continued from page 1 The Minimum Data Set (MDS) significant change assessment dated 5/12/26 revealed Resident #1 was severely cognitively impaired. He received oxygen therapy and had shortness of breath when at rest and lying flat. During an observation on 5/19/26 at 3:00 PM, Resident #1 was observed in his room wearing a nasal cannula connected to an oxygen concentrator delivering oxygen at 1 liter per minute. Resident #1 was resting with his eyes closed and showed no signs of acute distress. During an observation and interview on 5/20/26 at 10:00 AM, Resident #1 was again observed wearing a nasal cannula connected to an oxygen concentrator delivering oxygen at 1 liter per minute. Resident #1 was oriented to self and situation. When asked by the surveyor if he experienced shortness of breath at rest or with exertion, Resident #1 stated that he did. Review of Resident #1's electronic medical record on 5/20/26 revealed no current physician's order for supplemental oxygen. Review of Resident #1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated May 2026 revealed no order for oxygen therapy. The MAR did show that Resident #1's oxygen saturation (how much oxygen the blood is carrying) was monitored once daily from 5/10/26 through 5/12/26 then twice daily from 5/13/26 through 5/21/26 with readings ranging from 95-99% (Normal ranges 95-100%). A care plan revised 5/20/26 revealed Resident #1 was at risk for respiratory complications related to asthma and recent hospitalization. Interventions included to administer oxygen via nasal cannula as ordered. During an interview on 5/20/26 at 10:00 AM, Nurse #1 stated that Resident #1 had been receiving oxygen via nasal cannula since returning from the hospital on 5/5/26. Nurse #1 looked at the oxygen concentrator and stated Resident #1 was currently on one (1) liter per minute. She reported she did not know the ordered flow rate and would check the order. Nurse #1 later (approximately 12:00 pm) confirmed there was no oxygen order in Resident #1's electronic medical record and stated she was unsure what flow rate he should be receiving. She reported she would notify the Unit Manager. During an interview on 5/20/26 at 12:00 PM, the	F0695	Continued from page 1 their orientation process and no one will take an assignment until they have received the education. The facility implemented a process requiring nurse management review of all new oxygen-related orders for completeness prior to implementation. 4. Monitoring to Ensure Ongoing Compliance: The DON/designee will audit oxygen therapy orders weekly for 8 weeks to ensure orders contain clear administration and weaning parameters. Ad- HOC QAPI completed on 6/5/2026. Results of audits will be reviewed during QAPI meetings, and additional corrective actions or education will be provided as indicated.	06/11/2026

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F0695 SS = D	Continued from page 2 Unit Manager stated she could not locate an order for nasal cannula oxygen for Resident #1. She reported she had just notified the Nurse Practitioner and obtained a new order for nasal cannula oxygen at 2 liters per minute. The Unit Manager stated Resident #1 returned from the hospital on 5/5/26 on nasal cannula oxygen and that the admission nurse should have clarified the oxygen order since it was not on the hospital discharge summary. She stated she had not received any reports of Resident #1 experiencing shortness of breath or respiratory distress. An attempt was made to contact Nurse #2 who was the admission nurse on 5/5/26, and there was no response. During an interview on 5/21/26 at 11:00 AM, the Director of Nursing (DON) stated the oxygen order should have been clarified upon Resident #1's readmission by the admitting nurse and entered into the electronic medical record. The DON confirmed that oxygen therapy should not have been initiated or continued without a valid physician's order.	F0695		06/11/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and resident, staff, Physician and Wound Physician interviews, the facility failed to administer two prescribed medications, ketoconazole 2% shampoo (an antifungal shampoo used to reduce scalp flaking, scaling, and itching) and fluocinonide 0.05% topical solution (a topical steroid used to relieve inflammation and itching) in accordance with the physician's orders. This failure occurred for 1 of 3 residents reviewed for significant medication errors (Resident #1). Findings included: Resident #1 was admitted to the facility on 11/14/22 with diagnoses including seborrheic dermatitis (an inflammatory skin disorder affecting the scalp, face, upper chest, upper back, and skin folds. It presents as patches or plaques with inflammation, redness, and yellow, flaky scales that cause itching, burning,	F0760	Corrective Action for the Affected Resident: Resident #1's physician and responsible party were notified of the missed medication administration on 5/21/2026 Unit Manager. The medication administration record (MAR) was immediately reviewed and corrected on 5/21/2026 by the Unit Manager. Resident #1 was assessed for any adverse effects related to the missed dose, and new orders were obtained as indicated on 5/22/2026 by Unit Manager. Identification of Other Residents at Risk: An audit of current physician orders and MARs was completed for all residents receiving medications to ensure medications ordered were being administered as prescribed. Any discrepancies identified were immediately corrected on 5/22/2026 by the Unit Managers. Systemic Changes to Prevent Recurrence: Licensed nursing staff were re-educated on medication administration procedures, including verification of new orders, transcription accuracy, and timely administration of medications per physician orders by the Nurse Practice educator on 5/20/2026. All newly hired licensed nurses including	06/11/2026

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F0760 SS = D	Continued from page 3 and irritation). A physician's order from the Dermatologist's office dated 11/6/25 for Resident #1indicated an active order for ketoconazole 2% shampoo, to be applied twice weekly with good lather to the scalp and face, left in place for 2–5 minutes, then rinsed, for treatment of seborrheic dermatitis. A physician's order from the Dermatologist's office dated 11/6/25 for Resident #1 also indicated an active order for fluocinonide 0.05% topical solution (a high-potency topical corticosteroid used to reduce inflammation, redness and itching for skin conditions such as eczema, dermatitis, psoriasis and allergic rashes), to be applied to the affected scalp twice daily as needed for seborrheic dermatitis. Review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs) from 11/22/25 through 4/24/26 revealed no order for the ketoconazole shampoo. The fluocinonide order was listed on the MAR with no documentation that the as needed topical corticosteroid solution was administered to Resident #1. Review of nursing progress notes from 11/22/25 through 4/24/26 revealed no documentation indicating administration of either treatment or documentation indicating whether treatment was needed for Resident #1. Resident #1 was transported to the emergency department on 4/24/26 for an unrelated condition. Hospital records documented multiple thick, yellow-white crusted patches extending across the crown and back of the scalp. The hospital documentation did not indicate whether treatment was provided. Resident #1 was discharged back to the facility on 5/5/26. The Minimum Data Set (MDS) discharge return anticipated assessment dated 4/24/26 indicated Resident #1 had moderately impaired cognition and skin tears. Review of Resident #1's electronic medical record on 5/20/26 showed that ketoconazole shampoo and the as-needed fluocinonide topical solution remained active orders upon return from the hospital on	F0760	Continued from page 3 agency will receive the education in their orientation process and no one will take an assignment until they have received the education. The facility reinforced expectations regarding documentation and shift-to-shift communication concerning new medication orders. The DON/designee implemented a process for daily review of new orders against the MAR/TAR to ensure accuracy. 4.Monitoring to Ensure Ongoing Compliance: The DON/designee will conduct audits of new medication orders and corresponding MAR documentation 3 times weekly for 4 weeks, then weekly for 4 additional weeks. AD HOC QAPI completed on 6/5/2026. Findings will be reviewed through the facility's QAPI process, and additional education or corrective action will be implemented as needed based on audit findings.	06/11/2026

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F0760 SS = D	Continued from page 4 5/5/26. Review of the MAR and TAR from 5/5/26 through 5/20/26 again revealed no documented administration of the ketoconazole shampoo and no documented use of the as-needed fluocinonide topical solution for Resident #1. Review of the nursing progress notes from 5/5/26 through 5/20/26 revealed no documentation of treatment administration and no documentation indicating whether treatment was needed for Resident #1. An observation conducted on 5/20/26 at 10:00 AM with Nurse #1 and Nurse Aide #2 revealed Resident #1 lying in bed, and alert and oriented to self and situation. Resident #1 had thick, yellow-white crusted patches extending across the crown and back of the scalp, with redness and irritation noted along the posterior hairline. During an interview on 5/20/26 at 10:00 AM, Resident #1 was unable to state whether any scalp treatments had been administered. He reported that his scalp was itchy and sore. During an interview on 5/20/26 at 10:05 AM, Nurse #1 stated she routinely provided care to Resident #1 but was not aware of any scalp issues or of the orders for ketoconazole shampoo or as-needed fluocinonide. She reported she was unaware of any plaque buildup or irritation on his scalp. She stated Nurse Aides were responsible for shampooing residents' hair, but she did not know whether medicated shampoo was used. During an interview on 5/20/26 at 10:15 AM, Nurse Aide #2 stated she routinely cared for Resident #1 and indicated she did not recall if Resident #1's scalp had multiple scaly patches prior to his hospitalization on 5/5/26 but she had noticed irritation on his scalp at times including this morning, but she was not aware of any treatment and had never used medicated shampoo when washing his hair. Nurse Aide #2 indicated she had not reported this to Nurse #1 yet today, but she was planning to. During an interview on 5/20/26 at 11:00 AM, the Unit Manager stated Resident #1 had a chronic skin	F0760		06/11/2026

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F0760 SS = D	Continued from page 5 condition and previously received scheduled fluocinonide twice daily for symptom management. She stated the dermatologist changed the order to as needed on 11/6/25. The Unit Manager reported she was not aware that Resident #1 had multiple crusted scalp patches when sent to the hospital on 4/24/26 and was not aware he continued to have scalp issues. She stated the ketoconazole shampoo should have been administered twice weekly and the fluocinonide used when needed. The Unit Manager indicated that she or the assigned nurse would enter new orders into the electronic medical record but could not recall if she worked on 11/6/25 to enter new medication orders. During a phone interview on 5/21/26 at 9:00 AM, the Physician stated he was not aware of any concerns regarding Resident #1's scalp. He confirmed Resident #1 was followed by dermatology and stated medications should be administered as ordered. During an interview on 5/21/26 at 10:30 AM the Wound Physician stated ketoconazole shampoo and fluocinonide topical solution would be effective treatment for seborrheic dermatitis if they had been used. The Wound Physician stated the medications should have been administered to Resident #1. During an interview on 5/21/26 at 11:00 AM, the Director of Nursing (DON) confirmed the as-needed fluocinonide order was active and should have been administered to Resident #1 when symptoms were present. She also confirmed that the ketoconazole shampoo was an active order and should have been administered twice weekly as prescribed and acknowledged this was not done. The DON indicated that the ketoconazole shampoo wasn't transcribed from the dermatologist orders that were received on 11/6/25 and entered into Resident #1's electronic medical record, and the as needed fluocinonide was on the MAR as and was not administered. The DON stated the nurse on duty on 11/6/25 should have entered the ketoconazole into Resident #1's electronic medical record and that was not done. The DON stated the fluocinonide should have been administered when Resident #1 was symptomatic but that was not done. The DON stated the assigned nurse, or the Unit Manager, were responsible for entering new orders.	F0760		06/11/2026