PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345409	B. WING		C 05/31/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 000	from 5/11/23 through Jeopardy was identification and the second to the management review team returned to the the immediate jeoparthe exit date was characteristics.	ation survey was conducted	F 000				
	immediate jeopardy. allegations resulted in Immediate Jeopardy CFR 483.10 at tag F8 (J) CFR 483.25 at tag F8 (J)	•					
F 580 SS=J	Care. Immediate Jeopardy removed on 5/28/23. was conducted. Notify of Changes (In CFR(s): 483.10(g)(14) Notifi (i) A facility must immediate consistent with his or representative(s) who (A) An accident involved.	began on 5/5/23 and was A partial extended survey jury/Decline/Room, etc.) (i)-(iv)(15) cation of Changes. lediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which las the potential for requiring	F 58		6/12/23		
ABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	=	TITLE	(X6) DATE		

Electronically Signed 06/12/2023

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345409	B. WING		C 05/31/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	1 00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 580	a community of the second of t		F 58	30	
	mental, or psychosodeterioration in heal status in either life-t clinical complication (C) A need to alter the aneed to discontinuit reatment due to additional commence anew for (D) A decision to train resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this sectionall pertinent informatic is available and prorphysician. (iii) The facility must resident and the resident	reatment significantly (that is, le an existing form of verse consequences, or to orm of treatment); or insfer or discharge the cility as specified in stification under paragraph (g) in, the facility must ensure that tion specified in §483.15(c)(2) wided upon request to the also promptly notify the ident representative, if any, in or roommate assignment 1.10(e)(6); or dent rights under Federal or ons as specified in paragraph in. If record and periodically (mailing and email) and			

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-0391

OLIVILIV	OT OIL MEDIO, ILLE	WEDIO/ (ID OLI (VIOLO				OIVID ITC	7. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(C
		345409	B. WING			05/	31/2023
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PEMBRO	(E CENTER			_	10 E WARDELL DRIVE EMBROKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	by: Based on record revinterviews, the facility when Resident #1 de size of a nickel on his amounts of pus or drahistory of Fournier's glife-threatening bacte penis or perineum), a cavernosum (tissue for penis), and sepsis. Rabscesses at the emethospital #1 and transurology care. Hospital #1 and transurology care. Hospital #2 post opcomplicated by conting dysfunction (damage fed by the circulatory practice occurred for notification of change Immediate jeopardy by physician was not not Resident #1's scrotur removed on 5/28/23 and implemented and Immediate jeopardy rout of compliance at a of "D" (no harm with the minimal harm that is a ensure monitoring systeffective and the communications included:	is not met as evidenced few and staff and physician failed to notify the physician veloped an opened area the scrotum with significant ainage. Resident #1 had a gangrene (a rare, rial infection of the scrotum, bscess of corpus briming the bulk of the esident #1 was assessed for ergency department of ferred to Hospital #2 for I #2 operated on the scrotal d the Fournier's gangrene. berative stay was auing sepsis and end organ occurring in major organs system). This deficient 1 of 3 residents reviewed for (Resident #1). Degan on 5/5/23 when the tified of a new open area an. Immediate jeopardy was when the facility provided acceptable allegation of emoval. The facility remains a lower scope and severity the potential for more than anot immediate jeopardy) to stems put in place are upletion of staff education.	F	580	1. Resident #1 expired after transfer from the center to an acute setting. 2. All residents have the potential to affected. Change in condition assessments completed between 4/15/2023 and 5/15/2023 were reviewed by nursing leadership to ensure that proper notifications were made to the Physician, Advanced Practice Provider or on-call Physician/Advanced Practice Provider. No other residents were affected. 3. Education provided by the Directon Nursing and Nurse Practice Educator of Assessing residents, notifying the Physician, Advanced Practice Provider or on-call Physician/Advanced Practice Provider or on-call Physician/Advanced Practice Provider or on-call Physician/Advanced Practice Provider of changes in resident scondition; adequately documenting changes and notification; and how to respond to resident refusals of care/assessment. Education completer by May 17, 2023. 4. The Director of Nursing and/or designee will audit all resident change conditions to ensure that the Physician Advanced Practice Provider (s), or on-chysician/Advanced Practice Provider notified of the change for 30 days from 5/15/2023 then once weekly X 2 weeks then once monthly X 2 months.	be ed (s), (s), (s) d in , all is	
	Findings included:	nitted to the facility on 8/9/18.			5/15/2023 then once weekly X 2 weeks		

Facility ID: 923393

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345409	B. WING		C 05/31/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	1 03/31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 580	included paraplegia, implants, necrotizing infection that spreads cause death), Fournie life-threatening bacte penis or perineum), a cavernosum (tissue for penis), and sepsis. Resident #1's Minimulassessment dated 2/2 assessed as moderate active diagnoses inclusionanemia, hypertension bladder, diabetes me multiple sclerosis. He an indwelling cathete During an interview of #4 stated she provided #1 on 5/4/23 and note to his scrotum. The newas any swelling or resulting an interview of #2 stated on 5/5/23 decoording for the following and interview of #2 stated on 5/5/23 decoording for the sheets backwet with urine. She newas kinked under his tubing, got urine flow, him his medicine. She the nurse aides were short time later the nuand #2) told her Resignis scrotum that needs	the facility medical record presence of urogenital fasciitis (a rare bacterial quickly in the body and can er's gangrene (a rare, rial infection of the scrotum, bscess of corpus orming the bulk of the m Data Set (MDS) 16/23 revealed he was ely cognitively impaired. His uded wound infection, a, heart failure, neurogenic litus, paraplegia and was documented to have r and colostomy. In 5/11/23 at 10:21 AM Nurse ed wound care for Resident ed no skin breakdown areas urse did not indicate there	F 58	0	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			74. 50.25			، ا	2
		345409	B. WING			1	31/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2020
				3	310 E WARDELL DRIVE		
PEMBRO	KE CENTER			F	PEMBROKE, NC 28372		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
F 580	scrotum I need to loo "no." She told him sh sure he was okay, ar at it but don't touch it his scrotum, and ther of a nickel with no ble #1 then covered it up at it, and she told him it. He indicated they of Nurse #2 reported sh would let the oncominarea as the day shift stated this was arour next shift started at 7 told Nurse #1 about to report. She conclude examine the wound, report to the physicia	ve something on your k at," and he responded, e needed to see it to make ad he told her "You can look ." She stated she visualized e was an open area the size edding or drainage. Resident to, so she only had a brief look in they needed to take care of could take care of it later. The told Resident #1 she ang nurse know about the provided wound care. She ad 6:00 - 6:15 AM and the :00 AM. She stated she then the area at change of shift d since she could not she did not have anything to n so she did not notify the shift would do that when	F	580			
	Aide (NA) #1 stated in cleaned up on 5/5/23 often would refuse cat #2 entered Resident thought it was urine to when they first entered had happened to his suprapubic catheter at towel, which was on noted it was not urine appeared to be an operight side of his scrot ruptured open leaving drainage to the area. side of his scrotum a	on 5/11/23 at 10:55 AM Nurse Resident #1 needed to be in the early morning and he are. Both she and Nurse Aide #1's room. She stated they hat had leaked everywhere ed and assumed something catheter. Resident #1 had a and when they removed a top of his scrotum, they but fluid leaking from what ben area to his scrotum. The um appeared to have g black tissue and yellow. The area covered the right and was very alarming which nurse. She stated they					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED	
0.45.400	D WING			
345409	B. WING _	STREET ADDRESS CITY STATE 7ID CODE	05/	31/2023
		PEMBROKE, NC 28372		
PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETION DATE
about 5 minutes d indicated her assess the 2 that she was very d that he needed to ble as it was a very walked away, and back to Resident oncern to the happened around t 7:00 AM. B at 11:50 AM Nurse desident #1 on night 5/3/23 and 5/4/23. concerns were s scrotum during that shift. The time to her and tent as he had the stated this was tic catheter as well the went and got room to clean him d began cleaning d his brief to clean in his waist down to the that appearance of terrance of pus or tinued to clean him scrotum there was that appeared tack but flesh topen area and that they had to use rt of his scrotum to	F 58	30		
	ad5409 The Deficiencies Preceded By Full Fying Information) The Deficiencies Preceded By Full Fying Information The Deficiency Information The Deficie	345409 B. WING_ PRECIDENCIES PRECEDED BY FULL FYING INFORMATION) F 56 Inotified Nurse #2 to a labout 5 minutes do indicated ther assess the 2 that she was very walked away, and back to Resident concern to the happened around at 7:00 AM. B at 11:50 AM Nurse Resident was a very walked away, and back to Resident concern to the happened around at 7:00 AM. B at 11:50 AM Nurse Resident #1 on night 5/3/23 and 5/4/23. Concerns were as scrotum during the that shift. The tent to her and the stated this was both of the company of the word and gother for the proof of the proof	345409 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372 PECCEDED BY FULL FYING INFORMATION) PREFIX TAG F 580 F	345409 STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372 PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY AND SHOULD BE CROSS-RE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345409	B. WING _		C 05/31/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		03/3 1/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	#2 know that Reside had a new open are cleaned up pus and nurse indicated she then would go in an so NA #2 did not reponcoming nurse aid ended and she had Resident #1 and did assessed the reside. During an interview Aide #3 stated she is 5/5/23, from Nurse indicated Resident #emptied his cathete Aide #2 did not mer Resident #1 had a concerns from Nurse Aide #3 did in Resident #1's scrott assess it. During an interview #1 stated she was instated it was import no feeling to his ground tell if something stated on 5/5/23 she beginning at 7:00 A concerns from Nurse change of shift reponsassess or contact the Resident #1. She work completed her medidoing wound care a she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in to Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1. She seed the she was going in the Resident #1.	d she then went and let Nurse ent #1 was cleaned up but a to his scrotum and they had drainage but no urine. The was passing medications but d check on the resident after, port the concern to the e. She concluded her shift no further involvement with a not know if the nurse	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345409	345409 B. WING			C 5/31/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 310 E WARDELL DRIVE PEMBROKE, NC 28372	· · · · · · · · · · · · · · · · · · ·	5/5 1/2025
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 580	appearance of an the best way she of boiling an egg and white of the egg co came out was black tissue. She stated gangrene before a 5/5/23 had a similar she got the Director the area and they be sent out to the notified the on-call provider ordered for the hospital. Reside the facility at 6:50 Nurse #2 reported shift that morning, should have called informed of the area added that the phy informed of the resident out to be a Resident #1 was defected for PM, and at not temperature, other indicators of distreshe discharged. Review of Hospitare revealed Resident emergency depart groin and scrotum consulted for plan Consulting Surgeof for scrotal and perhad a history of drage streshe discharged for plan Consulting Surgeof for scrotal and perhad a history of drage streshe discharged for scrotal and perhad a history of drage streshe discharged for scrotal and perhad a history of drage for scrotal scrotal and perhad a history of drage for scrotal	esident #1's scrotum had the abscess that had ruptured and could describe it was to imagine when the egg cracks, the omes out. But in this case what sk and not normal looking Resident #1 had Fournier's not the tissue observed on a appearance. She reported or of Nursing (DON) to observe agreed Resident #1 needed to hospital. Nurse #1 stated she provider and the on-call or the resident to be sent out to lent #1 was discharged from PM. Nurse #1 denied that the area to her at change of She indicated Nurse #2 If the physician when she was as from the nurse aides. She resician should have been sident's refusal for treatment so all be made to send the assessed. Nurse #1 concluded discharged from the facility at time did he ever have a reabnormal vital signs, or ses during her shift including as a state of the ment with an abscess to the General surgery was of care or transfer. The on wrote, they were consulted all abscess and Resident #1 all anage of penile abscess, and debridement of Fournier's and resident #1 all anage of penile abscess, and debridement of Fournier's and resident #1 all anage of penile abscess, and debridement of Fournier's and resident #1 all anage of penile abscess, and debridement of Fournier's and resident #1 all anage of penile abscess.	F	580		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	
		345409	B. WING _			C 05/31/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 310 E WARDELL DRIVE PEMBROKE, NC 28372	CODE	1 00/1	3172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 580	years ago. The phys scrotum was swoller symptoms of an infer to the left side of the was an abscess on the draining pus. The as as well. The Consult treatment was beyon and recommended to #2. Review of Hospital # history and physical Resident #1 had a high paraplegia, and prior gangrene in April of Resident #1 was transpital with hypoter from his scrotum, perfor Fournier's gangrene to the operating room (surgical procedure to tissue) of scrotal absigning gangrene. The dischere the dischere wealed Resident #1 complicated by conting the dischere was and expired on 5/7/2 Attempts to contact procedure to the spire of the period on 5/11/2 and expired on 5/11/2 and expired on 5/11/2 and expired on 5/11/2 and expired on 5/11/2 are attempts were the physician #1 stated of the procedure of the procedur	at a different hospital a few ical exam revealed the and had signs and ction. The wound had spread scrotum and penis and there he left side of the penis sessment noted dead tissue ing Surgeon documented the id the scope of his practice ransfer to urology at Hospital 2's records revealed a dated 5/6/23 that noted story of multiple sclerosis, debridement for Fournier's 2022. The Physician noted insferred from an outside insion and purulent drainage insion and purulent drainage insion and perineum concerning ine. Resident #1 was taken in on 5/6/23 for debridement or remove dead or infected cess and Fournier's inarge summary dated 5/7/23 it's post operative stay was muing sepsis and end-organ was transferred to hospice 3. Onlysician at the hospital #1 is at 2:20 PM, 2:44 PM, and attempts made on 5/12/23 in on 5/17/23 at 5:18 PM.	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345409	B. WING _	B. WING		C 05/31/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 310 E WARDELL DRIVE PEMBROKE, NC 28372		5/31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	#1's scrotum until after and to his knowledge on call provider until though Nurse #2 was as the resident did so have notified him or topen area and the exconcluded it was hard outcome would have physician been notified drainage and abscess the resident out immediate and an advance of an open area drainage even if the massessment. During an interview of Administrator stated notified the physician aware of a new skin of Resident #1's scrotur concluded the nurse reported the new open During an interview of Director of Nursing stattempted to assess that Resident #1 was of the area. Nurse #2 oncoming shift of the and not having notified assessment and of the brought to her attention.	the open area on Resident the had been hospitalized, at it was not reported to any later that day, 5/5/23. Even to unable to assess the area of the on-call physician of the on-call physician of the oten of the drainage. He do to say if Resident #1's abeen different had the ed earlier that day about the state of the would have sent ediately upon being made as on his scrotum with resident did not allow a full on 5/11/23 at 12:53 PM the the nurse should have as soon as she was made opening and drainage from me by the nurse aide. He and nurse aides should have an area to the oncoming shift. In 5/31/23 at 9:52 AM the cated Nurse #2 should have the area or notify someone and allowing an assessment as should have notified the area, lack of assessment, and the doctor. Nurse #2 the doctor of the lack of the new area when it was on by the nurse aides.	F 5	80			

PRINTED: 07/18/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345409	B. WING _		C 05/31/2023	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	<u>'</u>	00/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580 Continued From page 10		F 5	80			
	allegation of immedia	the following credible ate jeopardy removal.				
		serious adverse outcome as				
	change of condition manner and failed to place for Nursing sta	notify the Physician of a for Resident #1 in a timely have effective systems in aff to know what changes and what needs to be				
	conducted a 30 look residents identified v verify Physician and timely manner. This May 17, 2023 and co of 24-hour reports, p	Nurses and/or designee back to review other vith a change in condition to /or Provider was notified in a review was completed by consisted of a thorough review rogress notes, and change of ints. No additional concerns				
	process or system fa	e entity will take to alter the allure to prevent a serious om occurring or recurring, and be complete				
	designee re-educate Notification of Change emphasis on change physician notification 27, 2023. Changes include a significant	tice Educator and/or ad Licensed Nurses on ges in Condition with es that require immediate a and documentation by May requiring prompt notification change in resident physical, cial status, an accident				

Facility ID: 923393

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345409	B. WING		C 05/31/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 310 E WARDELL DRIVE PEMBROKE, NC 28372		10/01/2020
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	potential for requiring need to alter treatmed decision to transfer of Additionally, re-educ Certified Nursing Assof changes in conditionanges to the Licenthe EInteract Stop a introduced as an earby direct care givers communicate change Licensed Nurse. The Nurse Practice Educemployees with scheabsence (FMLA), vare-educated prior to will be educated by the during the orientation. Effective May 15 Nurses and/or design condition by reviewing progress notes, charassessments, and stimorning Clinical Medimmediate notification Physician and/or Progress and/or Progress and/or Progressional films 2023	that results in injury or the physician intervention, a ant significantly, and a or discharge the resident. Action was completed with sistants on early identification on and prompt notification of sed Nurse by May 17, 2023. Ind Watch tool/alert was ally warning tool to be utilized as another mechanism to se in condition to the Director of Nursing and/or actor will track and verify that aduled time off, on leave of cation, or PRN staff will be returning to duty. New hires the Nurse Practice Educator in process. Sp. 2023, the Director of mee will review changes in the leting to verify prompt and/or in is communicated to the leting to verify prompt and/or in is communicated to the leting to Jeopardy is May 28, and is significantly and intervention of the leting to year of year o	F 58			
	removal with a comp validated on 5/31/23 interviews and in-ser in-services included the physician or on c residents, communic	on for immediate jeopardy liance date of 5/28/23 was , as evidenced by staff vice record reviews. The information on notification of all provider of changes in ation of change of conditions staff, and documenting the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345409	B. WING		C 05/31/2023
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	O BE COMPLETION
F 684	change in condition a The facility's immedia 5/28/23 was validated Quality of Care	is well as who was notified.	F 58		6/12/23
SS=J	applies to all treatme facility residents. Bas assessment of a resident residents receive accordance with profipractice, the compredicate plan, and the resident resi	andamental principle that and care provided to sed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of mensive person-centered sidents' choices. To is not met as evidenced sidents' choices. To is not met as evidenced sidents' choices. To is not met as evidenced sident and physician are and staff and physician are area on the scrotum that had significant amounts of sailed to seek urgent medical sident refused an and the significant and are ment for Fournier's gangrene is a type of (necrotizing fasciitis) that are of the scrotum, penis and ociated with a high mortality mediate medical attention. It to Hospital #1's emergency		 Resident #1 expired after transf from the center to an acute setting. All residents have the potential affected. All resident s skin assessifrom 5/18/23 5/28/23 were review new skin issues and to ensure that treatment orders are in place for exis skin injuries by nursing leadership. Nother residents were affected. Education was completed with Certified Nursing Assistants on utiliz of the STOP - & - WATCH form for reporting new changes in resident conditions to the primary nurse. Edu was completed with the Licensed Nu on Necrotizing Fasciitis, Fournier s Gangrene, and Gangrene; as well as assessing residents and what action 	to be ments ed for sting lo ation s cation urses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345409	B. WING			C 05/31/2023
NAME OF PI	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP C	ODE	05/31/2023
				310 E WARDELL DRIVE		
PEMBRO	KE CENTER			PEMBROKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	operative stay was consepsis and end-organioccurring in major organioccurring in major organization. However, we will be supported in the support of th	argical intervention. ery on 5/6/23 and his post implicated by continuing a dysfunction (damage gans fed by the circulatory sferred to hospice and is occurred for 1 of 3 r notification of change began on 5/5/23 when a not receive urgent medical Jeopardy was removed on lity provided and ptable allegation of removal. The facility ance at a lower scope and rm with the potential for arm that is not immediate monitoring systems put in d the completion of staff witted to the facility on 8/9/18. The facility medical record presence of urogenital fasciitis (a rare bacterial quickly in the body and can	F 68		es care. Director of e Educator. All ay 17, 2023. Assistants and lucated on the ng patient care This submitted ill be reviewed it to ensure any on are d change in d to ensure that ce and that will be s then once ce monthly X 2 I be monitored y X 2 weeks, All findings are	
	penis or perineum), a cavernosum (tissue fo penis), and sepsis. Resident #1's Minimulassessment dated 2/	bscess of corpus orming the bulk of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345409	B. WING _			05/3) 31/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372			7112020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page		F 6	84			
	anemia, heart failure bladder, diabetes me multiple sclerosis. Th	uded wound infection, , hypertension, neurogenic ellitus, paraplegia and le MDS indicated Resident catheter and colostomy.					
	he was care planned breakdown and has a included being sent to ruptured abscess to go included providing prodered, observe for of pain related to wood wound treatment and	actual skin breakdown which o the emergency room for a groin. The interventions eventative treatments as verbal and nonverbal signs und or wound treatment, I medication as ordered, and					
	Review of a progress #1 dated 5/1/23 reve check was completed previously identified	sents by licensed nurse. s note completed by Nurse aled a head-to-toe skin d. Resident #1 had skin issues noted, and no fied with Resident #1's					
	#1 stated she did a s 5/1/23 and found no	on 5/11/23 at 9:06 AM Nurse kin check on Resident #1 on new areas to his skin, just wounds to his sacrum, right					
	#4 stated she provide	on 5/11/23 at 10:21 AM Nurse ed wound care for Resident ed no skin changes to his					
		5/23 revealed Nurse #2 did ncerns for Resident #1.					
	During an interview o	on 5/11/23 at 11:28 AM Nurse					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILD	NG _		Ι,	3
		345409	B. WING				31/2023
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
DEMBRO	VE CENTED			3	10 E WARDELL DRIVE		
PEMBRU	KE CENTER			P	PEMBROKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	administer a medical stomach and when is she thought they we his indwelling cathet thigh. She unkinked and she was able to indicated she informagoing to clean him undication pass a shaides (Nurse Aides #1 had an open area to be assessed. She assess him and said something on your she responded, "no." see it to make sure he "You can look at it bushe visualized his so open area the size of drainage. Resident #1 only had a brief look needed to take care of it later. Nesident #1 she wouknow about the area wound care. She stated she contimedication pass and area at change of she since she could not on thave anything to she did not notify the would do that when the state of the state of the would do that when the would do that when the state of the state of the would do that when the would do that when the would do that when the state of the sta	around 6:00 AM she went to tion injection to Resident #1's she pulled the sheets back, re wet with urine. She noted er was kinked under his the tubing, got urine flow, give him his medicine. She ed him the nurse aides were p. In the middle of her nort time later the nurse #1 and #2) told her Resident a to his scrotum that needed stated she went down to	F	684			
	Aide (NA) #1 stated	Resident #1 needed to be 3 in the early morning and he					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
						С	
		345409	B. WING _			05/31/2023	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CC	DDE		
				310 E WARDELL DRIVE			
PEMBRO	KE CENTER			PEMBROKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Aide #2 entered Re thought it was urine when they first enter had happened to hi suprapubic cathete towel, which was or noted it was not uring appeared to be an aright side of his scrotum they indicated to the ensured his comfor assess the area. Not later Nurse #2 came Resident #1 had rearea. NA #1 then to concerned about the beassessed as soo pressing and acute away, and NA #1 the Resident #1, so she the oncoming nurse around 6:00 AM and During an interview Aide #2 stated she shift (7:00 PM to 7:00 the night shift of noted with Residen activities of daily liv morning of 5/5/23 Norequested she clear gotten urine all over	ge 16 care. Both herself and Nurse sident #1's room and she that had leaked everywhere ered and assumed something is catheter. Resident #1 had a rand when they removed a in top of his scrotum, they me but fluid leaking from what open area to his scrotum. The otum appeared to have ing black tissue and yellow in a. The area covered the right and was very alarming, which is nurse. She stated they it and then notified Nurse #2 to A #1 stated about 5 minutes in the rand indicated fused to let her assess the old Nurse #2 that she was very at area and that he needed to on as possible as it was a very issue. Nurse #2 then walked hought she was going back to be did not report the concern to be aide. This all happened in the resident #1 on night in the state of the same that the needed to on 5/11/23 at 11:50 AM Nurse cared for Resident #1 on night in the same that the had in the resident as he had in the resident as well in the same as a suprapubic catheter as well	F6	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	NG _		С	
		345409	B. WING				31/2023
NAME OF P	ROVIDER OR SUPPLIER		L	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2020
			310 E WARDELL DRIVE				
PEMBRO	KE CENTER			Р	PEMBROKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	him up and removed area. NA#2 stated the to his knees and it do furine but instead he drainage. She stated up and on the right is an area about the size slightly swollen but we colored. As they clear drainage was coming there was so much do a brief like pad on the keep him from becomagain. She stated is read to his scrotum and drainage but not she was passing me check on the resident the concern to the or concluded her shift end involvement with Resident #2 assessed to buring an interview of Aide #3 stated she to 5/5/23, from Nurse Aindicated Resident #1 had a change in the concern to the to conclude the shift end involvement with Resident #1 had a change in the concern to the or concluded her shift end involvement with Resident #1 had a change in the state of t	wn off and began cleaning his brief to clean his groin ere was fluid from his waist d not have the appearance had the appearance of pus or they continued to clean him lide of his scrotum there was the of a dime that appeared was not black but flesh and it, they noted that the grom that open area and trainage that they had to use the front part of his scrotum to ming soaked in drainage elet Nurse #2 know that and up but had a new open and they had cleaned up pus urine. Nurse #2 indicated dications but would go in and the after, so she did not report from the fident with the resident or not. On 5/11/23 at 10:13 AM Nurse ook report that morning, on ide #2 and the nurse aide 1 had a bath and she had and colostomy bags. Nurse ion anything which indicated hange of his scrotum, so thave a reason to visualize m or request the nurse	F	684			
	PM revealed Nurse #	s note dated 5/5/23 at 7:05 #1 went to Resident #1's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345409	B. WING _			C 05/31/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag		F 6	584		
	the nurse observed was swollen and app that was ruptured. T contacted at 6:22 Ph situation and an orde emergency departm	e resident onto his left side, that Resident #1's scrotum beared to have an abscess he on-call provider was M and made aware of the er was given to send to the ent for evaluation and e contacted 911 at 6:24 PM.				
	#1 stated she remer his regular nurse. Sh important to know R his groin and scrotur something was hurti 5/5/23 she worked a 7:00 AM. She was n from Nurse #2 with h shift report, so she h contact the physicial	on 5/11/23 at 9:06 AM Nurse nbered Resident #1 and was ne further stated it was esident #1 had no feeling to m so he could not tell if ng him there. She stated on 12-hour shift beginning at ot notified of any concerns Resident #1 during change of ad no reason to assess or m regarding Resident #1. She				
	medication passes to provide wound ca up her equipment ar removed his brief. N scrotum had the app had ruptured and the it was to imagine bo egg cracks, the whit in this case what can normal looking tissu had Fournier's gang observed on 5/5/23 She reported she go (DON) to observe th Resident #1 needed She added that the p	Around 6:00 PM it was time re for Resident #1. She set and pulled back his sheet and urse #1 stated Resident #1's rearance of an abscess that re best way she could describe ding an egg and when the re of the egg comes out. But me out was black and not re. She stated Resident #1 rene before and the tissue read a similar appearance. It the Director of Nursing re area and they agreed to be sent out to the hospital.				
		lent's refusal for treatment so I be made to send the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345409	B. WING _			C 05/31/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ue 19	F 6	684		
	notified the on-call p provider ordered for the hospital. Reside the facility at 6:50 Pl	sessed. Nurse #1 stated she rovider and the on-call the resident to be sent out to nt #1 was discharged from M.				
	Provider note that in history of necrotizing a severe scrotal abs foul-smelling drainag	ge which were concerning for				
	necrotizing infection as well. The Provider noted Resident #1 had no sensation to this area. A sepsis work up was ordered in addition to IV (intravenous) antibiotics and fluid resuscitation (due to hypotension). General surgery was					
	Consulting Surgeon scrotum was red and large area, approxim	care or transfer. The documented the entire d swollen and there was a nately 7 centimeters (cm) by 5 of the scrotum that was				
	pus. The underlying appeared to be drain noted the left side of	e) and draining foul smelling testicle was exposed and ning pus as well. It was also the penis had an abscess				
	documented Reside drainage of penile al debridement of Four	s. The Consulting Surgeon nt #1 had a history of oscess, scrotal abscess, and nier's gangrene by urology at few years ago. The				
	assessment noted d Consulting Surgeon was beyond the sco	ead tissue as well. The documented the treatment pe of his practice and fer to urology at Hospital #2.				
	history and physical	t2's records revealed a dated 5/6/23 that noted istory of multiple sclerosis,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345409	B. WING			C 05/24/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372	l	05/31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	gangrene in April of Resident #1 was tra hospital with hypote from his scrotum, per for Fournier's gangreto the operating roor (surgical procedure tissue) of scrotal abs gangrene. The discrevealed Resident # complicated by control dysfunction, and he and expired on 5/7/2 Attempts to contact made on 5/11/23 at PM, and further atte 9:52 AM and again of attempts were unsured attempts were unsured by the facinot made aware of the conclusion of the facinot made aware of the conclusion of the oped drainage. He conclusion of the oped drainage. He conclusion had the physician be about the drainage a have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and have sent the reside being made aware of the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of the oped about the drainage and the conclusion of	r debridement for Fournier's 2022. The Physician noted insferred from an outside insion and purulent drainage enis and perineum concerning ene. Resident #1 was taken in on 5/6/23 for debridement ito remove dead or infected scess and Fournier's harge summary dated 5/7/23 1's post operative stay was inuing sepsis and end-organ was transferred to hospice 23. physician at Hospital #1 were 2:20 PM, 2:44 PM, and 3:45 impts made on 5/12/23 at on 5/17/23 at 5:18 PM. These	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345409	B. WING _			C 05/31/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		00/01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Administrator stated notified the physicia aware of a new skir Resident #1's scrott was unable to asse nurse and nurse aid new open area to the During an interview Director of Nursing attempted to assess that Resident #1 was of the area on his sonotified the oncomin assessment, and not Nurse #2 should halack of assessment was brought to her. The Administrator wijeopardy on 5/26/23. The facility provided allegation of immediate Identify those recipions.	on 5/11/23 at 12:53 PM the di Nurse #2 should have in as soon as she was made in opening and drainage from the burner of the numby the nurse aides and is sthe area. He concluded the dies should have reported the ne oncoming shift. on 5/31/23 at 9:52 AM the stated Nurse #2 should have is the area or notify someone is not allowing an assessment crotum. Nurse #2 should have ing shift of the area, lack of ot having notified the doctor. We notified the doctor of the and of the new area when it attention by the nurse aides. Was notified of the immediate is at 2:01 PM. If the following credible is the jeopardy removal. The serious adverse outcome as	F6	84			
	Resident #1 and tal Resident #1 refused	conduct an assessment of se appropriate actions when d an assessment. Nurses and/or designee					
		k back to review other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345409	B. WING _			C 05/31/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 E WARDELL DRIVE PEMBROKE, NC 28372		00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	verify a thorough as: a Licensed Nurse. The Licensed Nurse of 24-hour reports, production assessment were identified. The Licensed Nurse of 24-hour reports, production assessment were identified. The Licensed Nurse of 24-hour reports of 24-hour reports, production assessment of 24-hour reports of 24-hour report	with a change in condition to sessment was completed by This review was completed by consisted of a thorough review progress notes, and change of ents. No additional concerns curses and/or designee sessment on all residents to a in condition and verify the evider was notified of changes or additional residents were tizing fasciitis and Fournier's see entity will take to alter the failure to prevent a serious of concerning or recurring, and	Fé	884		
	designee will provide Nurses on necrotizing angrene with specican progress, how describe seriousness/urgency medical attention by has been created and knowledge and/or control of Nurse Educator will track and (s) will be allowed to scheduled time off, of vacation, or PRN uncompleted the education of the education of the education of the educator during the educator during the	on leave of absence (FMLA), til they have successful ation/training and post-test. ucated by the Nurse Practice				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345409	B. WING _				C / 31/2023
	ROVIDER OR SUPPLIER	1		310	EET ADDRESS, CITY, STATE, ZIP CODE E WARDELL DRIVE	<u> </u>	10112020
				PEI	MBROKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	importance of conduction assessment, docume on specific measures an assessment to ince Responsible Party, a educating the reside allowing an assessment-eapproach by May Nursing and/or Nurse and verify Licensed I off, on leave of abse PRN staff will be residuty. New hires will Practice Educator du." The Nurse Practice Educator du. "The Nurse Practice Educator du condition and promp the Licensed Nurse I EInteract Stop and Vintroduced as an ear by direct care givers communicate change Licensed Nurse. The Nurse Practice Educemployees with schelabsence (FMLA), vare-educated prior to will be educated by the during the orientation "Effective May 15 Nurses and/or design condition by reviewir progress notes, charassessments, in the verify a thorough assecompleted.	e Licensed Nurses on the cting a thorough enting the assessment, and is to take if a patient refuses clude notifying the and Physician/Provider, and not on the importance of the to be completed, and 27, 2023. The Director of the Practice Educator will track Nurses with scheduled time noce (FMLA), vacation, or reducated prior to returning to be educated by the Nurse uring the orientation process. Itice Educator and/or and Certified Nursing dentification of changes in the notification of changes to by May 17, 2023. The Vatch tool/alert was another mechanism to the endition of the endition to the endition of the endition of the endition of the endition to the endition to the endition to the endition of the endition of the endition of the endition of the endition to the endition of the endit	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345409	B. WING			C 05/31/2023	
NAME OF PROVIDER OR SUPPLIER PEMBROKE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		Fé	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			