

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL092212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/12/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DUNMORE SENIOR LIVING OF ZEBULON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 W GANNON AVENUE ZEBULON, NC 27597</b>
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D 000	Initial Comments  The Adult Care Licensure Section conducted an annual and follow-up survey on 03/10/26 - 03/12/26.	D 000		
D 234	<p>10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam &amp; Immunizatio</p> <p>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination &amp; Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled residents (#1, #2, #5) were tested for tuberculosis (TB) disease in compliance with the guidelines from the Centers for Disease Control and Prevention.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 11/12/25 revealed diagnoses included contractures, collagenous colitis, and T-cell lymphoma.</p> <p>Review of Resident #1's Resident Register dated 10/28/25 revealed she was admitted to the facility from a residence on 10/30/25.</p>	D 234		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 234	<p>Continued From page 1</p> <p>Review of Resident #1's record revealed: -There was documentation that a 1st step tuberculosis (TB) test was administered on 10/14/25 and read as negative on 10/16/25. -There was no documentation that a 2nd step TB test was administered and read. -There was no documentation for a chest x-ray.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:35am.</p> <p>Refer to interview with the Administrator on 03/11/26 at 8:56am.</p> <p>2. Review of Resident #2's current FL-2 dated 02/04/26 revealed diagnoses included chronic kidney disease, unsteady gait, delirium, schizophrenia, and Vitamin D deficiency.</p> <p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 07/28/25 from his own residence.</p> <p>Review of Resident #2's tuberculosis (TB) skin tests revealed: -There was documentation of a TB skin test placed on 07/11/25 and read as negative on 07/14/25. -There was no documentation of any other TB skin tests for Resident #2.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:35am.</p> <p>Refer to interview with the Administrator on 03/11/26 at 8:56am.</p> <p>3. Review of Resident #5's current FL-2 dated 01/19/26 revealed diagnoses included diabetes</p>	D 234		

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D 234	<p>Continued From page 2</p> <p>mellitus, chronic kidney disease, and chronic obstructive pulmonary disease.</p> <p>Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 04/07/23 from his own residence.</p> <p>Review of Resident #5's tuberculosis (TB) skin tests revealed: -There was documentation of a TB skin test placed on 04/11/23 and read as negative on 04/14/23. -There was no documentation of any other TB skin tests for Resident #5.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:35am.</p> <p>Refer to interview with the Administrator on 03/11/26 at 8:56am.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:35am revealed: -She thought the 1st and 2nd step TB tests were done before admission. -She and the Administrator were responsible for reviewing residents' records to ensure the TB tests were done. -She was not aware residents' TB tests were not done.</p> <p>Interview with the Administrator on 03/11/26 at 8:56am revealed: -The residents' records were audited within the last 3 years. -The RCC was responsible for ensuring the residents admitted to the facility had their 1st and 2nd step TB tests. -She believed a former staff person removed some files including TB tests from the residents'</p>	D 234		

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D 234	Continued From page 3 records.	D 234		
D 344	<p>10A NCAC 13F .1002(a) Medication Orders</p> <p>10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were clarified for 2 of 5 sampled residents (#1, #5) including controlled substances used to treat moderate to severe pain (#1) and a blood thinner used to treat and prevent blood clots (#5).</p> <p>The findings are:</p> <p>Review of the facility's medication policy dated September 2021 revealed if medication orders were not clear or complete, the facility should ensure to contact the resident's physician or prescribing practitioner for clarification of orders for medications.</p>	D 344		

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D 344	<p>Continued From page 4</p> <p>1. Review of Resident #5's current FL-2 dated 01/19/26 revealed: -Diagnoses included diabetes mellitus, chronic kidney disease, and chronic obstructive pulmonary disease. -There was an order for Warfarin 2.5mg 1 tablet 3 times weekly on Monday, Wednesday, and Friday and Warfarin 5mg 1 tablet once daily on Sunday, Tuesday, Thursday, and Saturday. (Warfarin is a blood thinner used to prevent blood clots.)</p> <p>Review of Resident #5's visit note from the Veteran's Administration (VA) Anticoagulant Clinic dated 02/18/26 revealed: -The resident's target INR goal was 2.0 - 3.0. [International Normalized Ratio (INR) is a lab value used to monitor Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations.] -Resident #5's INR was checked today, 02/18/26, and it was 2.26 (within the goal range). -There were instructions to stay on the same dose of Warfarin the resident was currently on. -The current dose was noted to be Warfarin 2.5mg on Monday and Wednesday and Warfarin 5mg on Tuesday, Thursday, Friday, Saturday, and Sunday. -The resident's next INR lab appointment was on 03/12/26. -The visit note was not signed by a prescribing practitioner.</p> <p>Review of Resident #5's physician's orders, provider visit notes, and progress notes revealed no documentation the resident's Warfarin order was clarified.</p> <p>Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed:</p>	D 344		

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D 344	<p>Continued From page 5</p> <p>-There was an entry for Warfarin 2.5mg 1 tablet 3 times weekly on Monday, Wednesday, and Friday scheduled at 5:00pm. -Warfarin 2.5mg was documented as administered on Monday, Wednesday, and Friday from 01/01/26 - 01/31/26. -There was an entry for Warfarin 5mg 1 tablet once daily on Sunday, Tuesday, Thursday, and Saturday scheduled at 5:00pm. -Warfarin 5mg was documented as administered once daily on Sunday, Tuesday, Thursday, and Saturday from 01/01/26 - 01/31/26. -There were no entries for Warfarin 2.5mg on Monday and Wednesday and Warfarin 5mg on Tuesday, Thursday, Friday, Saturday, and Sunday as indicated by the VA Anticoagulant Clinic.</p> <p>Review of Resident #5's February 2026 eMAR revealed: -There was an entry for Warfarin 2.5mg 1 tablet 3 times weekly on Monday, Wednesday, and Friday scheduled at 5:00pm. -Warfarin 2.5mg was documented as administered on Monday, Wednesday, and Friday from 02/01/26 - 02/28/26. -There was an entry for Warfarin 5mg 1 tablet once daily on Sunday, Tuesday, Thursday, and Saturday scheduled at 5:00pm. -Warfarin 5mg was documented as administered once daily on Sunday, Tuesday, Thursday, and Saturday from 02/01/26 - 02/28/26. -There were no entries for Warfarin 2.5mg on Monday and Wednesday and Warfarin 5mg on Tuesday, Thursday, Friday, Saturday, and Sunday as indicated by the VA Anticoagulant Clinic.</p> <p>Review of Resident #5's March 2026 eMAR revealed:</p>	D 344		

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D 344	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-There was an entry for Warfarin 2.5mg 1 tablet 3 times weekly on Monday, Wednesday, and Friday scheduled at 5:00pm.</li> <li>-Warfarin 2.5mg was documented as administered on Monday, Wednesday, and Friday from 03/01/26 - 03/09/26.</li> <li>-There was an entry for Warfarin 5mg 1 tablet once daily on Sunday, Tuesday, Thursday, and Saturday scheduled at 5:00pm.</li> <li>-Warfarin 5mg was documented as administered once daily on Sunday, Tuesday, Thursday, and Saturday from 03/01/26 - 03/08/26.</li> <li>-There were no entries for Warfarin 2.5mg on Monday and Wednesday and Warfarin 5mg on Tuesday, Thursday, Friday, Saturday, and Sunday as indicated by the VA Anticoagulant Clinic.</li> </ul> <p>Observation of Resident #2's medications on hand on 03/11/26 at 11:29am revealed:</p> <ul style="list-style-type: none"> <li>-There was a bottle of 90 Warfarin 5mg tablets dispensed from a VA pharmacy on 09/19/25.</li> <li>-There was a second bottle of 90 Warfarin 5mg tablets dispensed from a VA pharmacy on 01/14/26.</li> <li>-The instructions on both bottles were to take ½ tablet (2.5mg) on Monday and Wednesday and 1 tablet (5mg) on all other days.</li> <li>-There were 78 whole Warfarin 5mg tablets in one bottle and 149 of the half tablets (2.5mg) in the other bottle remaining.</li> </ul> <p>Review of Resident #5's VA Coagulation Profile dated 03/10/26 revealed:</p> <ul style="list-style-type: none"> <li>-The resident's INR was 2.28 on 02/17/26.</li> <li>-The resident's INR was 2.63 on 01/07/26.</li> <li>-The resident's INR was 2.27 on 12/03/25.</li> <li>-The resident's INR was 2.30 on 10/23/25.</li> <li>-The resident's INR was 2.30 on 09/16/25</li> </ul>	D 344		

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D 344	<p>Continued From page 7</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/26 at 10:33am revealed:</p> <ul style="list-style-type: none"> <li>-They were responsible for entering Resident #5's orders into the eMAR system but they did not dispense medications for Resident #5.</li> <li>-The most current order they had on file for Resident #5's Warfarin was dated 11/18/25 to take 2.5mg on Monday, Wednesday, and Friday and 5mg on Tuesday, Thursday, Saturday, and Sunday.</li> </ul> <p>Telephone interview with Resident #5's family member on 03/11/26 at 3:11pm revealed:</p> <ul style="list-style-type: none"> <li>-He usually took Resident #5 to the VA Anticoagulant Clinic for INR checks.</li> <li>-The VA Anticoagulant Clinic usually verified the resident's Warfarin order with him during the visit.</li> <li>-He thought the resident was taking Warfarin according to the instructions on the labels of the Warfarin bottles provided by the VA pharmacy.</li> <li>-He was not aware Resident #5 was not receiving the dosage of Warfarin that was indicated by the VA and the prescription labels.</li> </ul> <p>Interview with a medication aide on 03/11/26 at 3:55pm revealed:</p> <ul style="list-style-type: none"> <li>-She administered Resident #5's Warfarin dosage according to instructions on the eMAR.</li> <li>-She had not noticed the instructions on the medication label did not match the instructions on the eMAR for Resident #5's Warfarin.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 1:05pm revealed</p> <ul style="list-style-type: none"> <li>-She was responsible for clarifying medication orders.</li> <li>-She had not noticed the discrepancy with Resident #5's Warfarin dosage until the surveyor brought it to her attention.</li> </ul>	D 344		

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D 344	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-The MAs should notify her if the medication label and eMAR did not match.</li> <li>-The MAs had not notified her of any discrepancies with Resident #5's Warfarin.</li> </ul> <p>Interview with the Administrator on 03/12/26 at 1:10pm revealed:</p> <ul style="list-style-type: none"> <li>-The RCC was responsible for clarifying medication orders.</li> <li>-There was no system to check behind the RCC.</li> </ul> <p>Telephone interview with a pharmacist at Resident #5's VA Anticoagulant Clinic on 03/12/26 at 11:19am revealed:</p> <ul style="list-style-type: none"> <li>-They were not aware of any changes in Resident #5's Warfarin dosage.</li> <li>-They thought the resident was receiving Warfarin as indicated in his VA orders and on the VA prescription labels.</li> <li>-No one had contacted them to clarify Resident #5's Warfarin order prior to 03/10/26.</li> <li>-The resident could have bleeding if he received too much Warfarin or could have another stroke if he did not receive enough Warfarin.</li> <li>-Resident #5's INRs were in the goal range.</li> </ul> <p>Attempted telephone interview with Resident #5's VA primary care provider (PCP) on 03/12/26 at 11:55am was unsuccessful.</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:39am.</p> <p>Refer to second interview with the RCC on 03/12/26 at 9:28am.</p> <p>Refer to interview with the Administrator on 03/11/26 at 8:56am.</p> <p>Refer to second interview with the Administrator</p>	D 344		

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D 344	<p>Continued From page 9</p> <p>on 03/12/26 at 8:36am.</p> <p>2. Review of Resident #1's current FL-2 dated 11/12/25 revealed diagnoses included contractures, collagenous colitis, and T-cell lymphoma.</p> <p>Review of Resident #1's physician orders dated 12/18/25 revealed there was an order for Hydrocodone 7.5mg Acetaminophen 325mg tablet, take 1 tablet every 6 hours as needed (PRN) for pain. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.)</p> <p>Review of Resident #1's physician's order dated 01/07/26 revealed: -The blank orders were printed on 12/05/25. -There was an order for Oxycodone 5mg tablet, take 1 tablet every 6 hours PRN for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain.)</p> <p>Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 5mg tablet, take 1 tablet every 6 hours PRN for pain. -There was documentation that Oxycodone 5mg was discontinued on 12/12/25. -There was an entry for Hydrocodone 7.5mg Acetaminophen 325mg, take 1 tablet every 6 hours PRN for pain. -There was documentation that Hydrocodone 7.5mg Acetaminophen 325mg tablet was administered on 12/18/25.</p> <p>Review of Resident #1's January 2026 eMAR revealed: -There was an entry for Hydrocodone 7.5mg</p>	D 344		

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D 344	<p>Continued From page 10</p> <p>Acetaminophen 325mg, take 1 tablet every 6 hours PRN for pain. -There was documentation the Hydrocodone 7.5mg Acetaminophen 325mg tablet was administered 12 times.</p> <p>Review of Resident #1's February 2026 eMAR revealed: -There was an entry for Hydrocodone 7.5mg Acetaminophen 325mg, take 1 tablet every 6 hours PRN for pain. -There was documentation the Hydrocodone 7.5mg Acetaminophen 325mg tablet was administered 4 times.</p> <p>Review of Resident #1's March 2026 eMAR revealed: -There was an entry for Hydrocodone 7.5mg Acetaminophen 325mg, take 1 tablet every 6 hours PRN for pain. -There was documentation the Hydrocodone 7.5mg Acetaminophen 325mg tablet was administered 1 time.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 9:28am revealed: -Resident #1's physician's orders were printed from the eMAR system. -She should have reprinted Resident #1's physician's orders before the primary care provider (PCP) signed them in January 2026.</p> <p>Telephone interview with a pharmacist at the the facility's contracted pharmacy on 03/11/26 at 11:40am revealed: -The Hydrocodone 7.5mg Acetaminophen 325mg was a step down from the Oxycodone 5mg tablet. -The pharmacy received a discontinued order for the Oxycodone 5mg tablet on 12/11/25.</p>	D 344		

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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) COMPLETE DATE
D 344	<p>Continued From page 11</p> <p>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:39am.</p> <p>Refer to second interview with the RCC on 03/12/26 at 9:28am.</p> <p>Refer to interview with the Administrator on 03/11/26 at 8:56am.</p> <p>Refer to second interview with the Administrator on 03/12/26 at 8:36am.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 8:39am revealed: -She was responsible for ensuring the physician's orders matched the electronic medication administration records (eMARs). -She was responsible for checking medication orders before the primary care provider (PCP) signed them.</p> <p>Second interview with the RCC on 03/12/26 at 9:28am revealed: -When she clarified medication orders, she contacted the PCP and faxed the order to the pharmacy. -After she received a clarified medication order, she ensured it was placed in the eMAR system.</p> <p>Interview with the Administrator on 03/11/26 at 8:56am revealed: -The RCC was responsible for clarifying medication orders. -She was not aware residents had medication orders that needed to be clarified.</p> <p>Second interview with the Administrator on 03/12/26 at 8:36am revealed: -The RCC should notify the PCP when medication orders needed to be clarified.</p>	D 344		

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D 344	Continued From page 12  -The old medication orders should have been compared to the new orders to ensure any new orders were put in place.	D 344		
D 358	<p>10A NCAC 13F .1004 (a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#5) sampled for record review including errors with a diuretic used to treat swelling caused by excess fluid and a rapid-acting insulin used to lower blood sugar.</p> <p>The findings are:</p> <p>Review of Resident #5's current FL-2 dated 01/19/26 revealed diagnoses included diabetes mellitus, chronic kidney disease, and chronic obstructive pulmonary disease.</p> <p>a. Review of Resident #5's urgent care provider visit note dated 01/29/26 revealed: -The resident was seen for peripheral edema (swelling in the legs due to fluid buildup) and</p>	D 358		

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D 358	<p>Continued From page 13</p> <p>cracking skin.</p> <p>-There were instructions to follow up with the resident's primary care provider (PCP) as soon as possible for further evaluation to check the resident's kidneys and heart and start "water pill" if needed. (Water pill refers to diuretics, medications used to remove excess fluid from the body.)</p> <p>Review of Resident #5's Veteran's Administration (VA) PCP televisit note dated 02/11/26 revealed:</p> <p>-The resident reported swelling in his legs and feet.</p> <p>-The resident had been to a local urgent care but continued to have swelling.</p> <p>-There were no new medication orders for this visit.</p> <p>Review of Resident #5's VA nephrology provider clinic visit note dated 02/17/26 revealed:</p> <p>-The resident had lower extremity swelling.</p> <p>-There was an order to start Furosemide 20mg daily for lower extremity swelling. (Furosemide is a diuretic used to treat swelling caused by excess fluid in the body.)</p> <p>-The resident was to follow-up in one month.</p> <p>Review of Resident #5's February 2026 electronic medication administration record (eMAR) revealed there was no entry for Furosemide 20mg 1 tablet daily for lower extremity swelling and none was documented as administered.</p> <p>Review of Resident #5's March 2026 eMAR revealed there was no entry for Furosemide 20mg 1 tablet daily for lower extremity swelling and none was documented as administered.</p> <p>Observation of Resident #5's medications on hand on 03/11/26 at 3:51pm revealed:</p>	D 358		

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D 358	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-There was a bottle of Furosemide 20mg tablets dispensed on 02/17/26 stored in the cabinet in a basket with Resident #5's name.</li> <li>-The instructions were to take 1 tablet in the morning for accumulation of fluid.</li> <li>-There were 87 of 90 Furosemide 20mg tablets remaining in the bottle.</li> <li>-The letters "AM" were handwritten in black marker on the top of the bottle lid.</li> <li>-There were no Furosemide 20mg tablets stored with the actively used medications in the medication cart.</li> </ul> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/26 at 10:33am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5 was "profile only" with their pharmacy because they did not dispense any medications for the resident.</li> <li>-The facility was responsible for sending orders for Resident #5 to them.</li> <li>-They entered orders into the eMAR system for Resident #5.</li> <li>-They never received an order for Furosemide 20mg for Resident #5.</li> <li>-Not receiving Furosemide could cause Resident #5 to have increased swelling.</li> </ul> <p>Interview with a medication aide (MA) on 03/11/26 at 3:55pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5 went to urgent care recently (could not recall date) for a rash and "puffiness" in his legs and feet.</li> <li>-She thought Resident #5's legs seemed a little better since then.</li> <li>-Resident #5's medications were not filled by the facility's contracted pharmacy.</li> <li>-Resident #5's family member usually brought the resident's medications to the facility.</li> <li>-She had received medications from Resident</li> </ul>	D 358		

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D 358	<p>Continued From page 15</p> <p>#5's family member at times and she may have received the supply of Furosemide from the family member.</p> <p>-When she received medication from Resident #5's family member, she would put it in the resident's back up supply of medication if the same medication was already in the medication cart to prevent duplicates.</p> <p>-She would put the medication in the medication cart if there was none already in the cart.</p> <p>-If she received any paperwork from the family, she usually filed it in the resident's record.</p> <p>-She could not recall when she last received medications or paperwork for Resident #5.</p> <p>-If MAs received orders for Resident #5, they usually wrote "profile only" on the paper and faxed it to the facility's contracted pharmacy so the orders could be entered into the eMAR system.</p> <p>-She did not recall if she had faxed an order for Resident #5's Furosemide to the facility's contracted pharmacy.</p> <p>-She did not recall if she administered any Furosemide 20mg to Resident #5.</p> <p>Telephone interview with Resident #5's family member on 03/11/26 at 3:11pm revealed:</p> <p>-Resident #5's saw health care providers and received medications from a VA health care system.</p> <p>-The facility would notify him when the resident needed medications and he would order them and deliver them to the facility.</p> <p>-The resident was seen by the nephrology clinic recently for swelling in his feet and ankles.</p> <p>-The nephrology clinic ordered Furosemide for the swelling, and he picked it up from the VA pharmacy and delivered it to the facility on 02/21/26.</p> <p>-If he was given any paperwork at the VA provider</p>	D 358		

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D 358	<p>Continued From page 16</p> <p>visits, he gave it to the facility staff, usually the MAs.</p> <p>-No one at the facility had contacted him with any concerns about Resident #5's Furosemide or any other medication orders until today.</p> <p>-The resident had a follow-up appointment to be seen by the nephrology provider who ordered the Furosemide tomorrow, 03/12/26.</p> <p>Second interview with Resident #5's family member on 03/12/26 at 12:15pm revealed:</p> <p>-He brought the Furosemide 20mg tablets to the facility on the same day he picked it up from the VA pharmacy.</p> <p>-The bottle was sealed and had not been opened when he delivered it to a MA at the facility.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 4:09pm revealed:</p> <p>-She was not aware until it was brought to her attention by the surveyor today that Resident #5 had an order for Furosemide.</p> <p>-She sometimes had a difficult time getting orders for Resident #5 because he saw providers in the VA health care system.</p> <p>-She had the VA fax visit notes with the order for Resident #5's Furosemide today, 03/11/26.</p> <p>-The MA who received the Furosemide from Resident #5's family should have checked the medication received with the order and eMAR.</p> <p>-The MAs should have notified her since Furosemide was not on Resident #5's eMAR but available for administration.</p> <p>-The MAs should fax any orders to the facility's contracted pharmacy to be entered into the eMAR system and then file the orders in the resident's record.</p> <p>-She was new as the RCC and she did not currently have a system to audit the orders and eMARs.</p>	D 358		

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D 358	<p>Continued From page 17</p> <p>Observation of Resident #5 with the RCC on 03/11/26 at 4:20pm revealed: -Both of Resident #5's lower legs and the tops of his feet were swollen. -The resident's left ankle was swollen more than the right ankle.</p> <p>Second interview with the RCC on 03/11/26 at 4:20pm revealed: -She was a licensed practical nurse (LPN). -Resident #5 had 1+ pitting edema (indicates mild swelling with a slight indentation that rebounds in a few seconds when the skin is pressed) in both legs.</p> <p>Interview with Resident #5 on 03/11/26 at 4:20pm revealed: -He denied any pain in his legs or feet. -The swelling caused his shoes to feel tight on his feet. -His shoes did not feel as tight today as they did yesterday.</p> <p>Interview with the Administrator on 03/12/26 at 1:10pm revealed: -The MAs should administer medications as ordered. -The RCC was responsible for making sure medication orders were implemented and followed.</p> <p>Telephone interview with a nephrology provider with Resident #5's nephrology clinic on 03/12/26 at 10:50am revealed: -Resident #5 was seen by a different nephrology provider on his last visit. -Furosemide was started on Resident #5's last visit on 02/17/26, due to swelling. -Furosemide would help with the resident's</p>	D 358		

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D 358	<p>Continued From page 18</p> <p>volume status by removing excess fluid.</p> <p>-Resident #5 had stage 3 and 4 chronic kidney disease so his kidneys could not process excess fluid.</p> <p>-Not receiving Furosemide could cause Resident #5's swelling to get worse.</p> <p>b. Review of Resident #5's current FL-2 dated 01/19/26 revealed there was an order for Novolog insulin inject 3 units subcutaneously (SQ) 3 times daily with meals, hold for blood sugar less than (&lt;) 140. (Novolog is rapid-acting insulin used to lower blood sugar.)</p> <p>Review of Resident #5's February 2026 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for Novolog insulin inject 3 units SQ 3 times daily with meals, hold for blood sugar &lt; 140.</p> <p>-Novolog insulin was scheduled to be administered at 9:00am, 12:00pm, and 5:00pm.</p> <p>-The resident's blood sugar was 130 on 02/22/26 at 9:00am and 3 units of Novolog insulin were documented as administered including the injection site but should have been held.</p> <p>-The resident's blood sugar was 135 on 02/27/26 at 9:00am and 3 units of Novolog insulin were documented as administered including the injection site but should have been held.</p> <p>-The resident's blood sugar was 134 on 02/21/26 at 12:00pm and 3 units of Novolog insulin were documented as administered including the injection site but should have been held.</p> <p>-The resident's blood sugar ranged from 81 - 299 from 02/01/26 - 02/28/26.</p> <p>Review of Resident #5's March 2026 electronic medication administration record (eMAR) revealed:</p>	D 358		

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D 358	<p>Continued From page 19</p> <ul style="list-style-type: none"> <li>-There was an entry for Novolog insulin inject 3 units SQ 3 times daily with meals, hold for blood sugar &lt; 140.</li> <li>-Novolog insulin was scheduled to be administered at 9:00am, 12:00pm, and 5:00pm.</li> <li>-The resident's blood sugar was 140 on 03/09/26 at 9:00am and 0 units were documented as administered but 3 units should have been administered since the blood sugar was not &lt; 140.</li> <li>-The resident's blood sugar ranged from 111 - 281 from 03/01/26 - 03/10/26.</li> </ul> <p>Observation of Resident #5's medications on hand on 03/11/26 at 11:39am revealed:</p> <ul style="list-style-type: none"> <li>-There was a box of Novolog insulin pens dispensed on 02/17/26.</li> <li>-There were 4 unopened Novolog insulin pens in the box.</li> <li>-The instructions on the medication label were to inject 3 units 3 times a day with meals for diabetes, if blood sugar is &lt; 140, do not give insulin.</li> <li>-There was one opened Novolog insulin pen in the medication cart that was documented as being opened on 03/03/26.</li> </ul> <p>Interview with Resident #5 on 03/11/26 at 10:49am revealed:</p> <ul style="list-style-type: none"> <li>-He usually received an insulin injection in his arm about once a day.</li> <li>-He thought his blood sugar was checked about 3 times a day.</li> <li>-He did not refuse insulin.</li> <li>-He did not think his insulin was held, they always gave insulin to him.</li> </ul> <p>Telephone interview with a medication aide (MA) on 03/12/26 at 2:30pm revealed:</p> <ul style="list-style-type: none"> <li>-She could not recall if she held Resident #5's</li> </ul>	D 358		

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D 358	<p>Continued From page 20</p> <p>Novolog insulin. -If insulin was held, it should be documented on the eMAR as held because the blood sugar was too low. -She usually documented the site of insulin injections and the number of units administered on the eMAR. -She did not know why she would have administered Resident #5's Novolog insulin when it should have been held.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 1:05pm revealed: -The MAs should slow down and read the instructions on the eMAR when administering medications. -The MAs should hold Resident #5's Novolog insulin if his blood sugar was &lt; 140.</p> <p>Interview with the Administrator on 03/12/26 at 1:10pm revealed: -The MAs should follow the medication orders. -The MAs should not administer Novolog insulin to Resident #5 if his blood sugar was &lt; 140.</p> <p>Attempted telephone interviews with Resident #5's primary care provider (PCP) on 03/12/26 at 11:36am and 11:55am were unsuccessful.</p> <p>_____</p> <p>The facility failed to administer medications as ordered to Resident #5. Resident #5 did not receive a diuretic for swelling in his legs and feet that was ordered on 02/17/26 after an urgent care visit for swelling in his legs. Resident #5 had chronic kidney disease which prevented him from processing excess fluid and put the resident at risk of worsening swelling. Resident #5 had 1+ pitting edema (swelling) in his legs on 03/11/26 after not receiving Furosemide as ordered since 02/17/26. This failure of the facility was</p>	D 358		

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D 358	Continued From page 21  detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/11/26 for this violation.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26, 2026.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration  10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	<p>Continued From page 22</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 5 sampled residents (#5) including documentation for a rapid-acting insulin with parameters to hold the insulin based on the resident's fingerstick blood sugar results.</p> <p>The findings are:</p> <p>Review of Resident #5's current FL-2 dated 01/19/26 revealed: -Diagnoses included diabetes mellitus, chronic kidney disease, and chronic obstructive pulmonary disease. -There was an order for Novolog insulin inject 3 units subcutaneously (SQ) 3 times daily with meals, hold for blood sugar less than (&lt;) 140. (Novolog is rapid-acting insulin used to lower blood sugar.)</p> <p>Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin inject 3 units SQ 3 times daily with meals, hold for blood sugar &lt; 140. -Novolog insulin was scheduled to be administered at 9:00am, 12:00pm, and 5:00pm. -There was a row to document the site of the injection and a row to document the amount given. -Novolog insulin was documented as administered on 16 of 25 occasions when Resident #5's blood sugar was &lt; 140. -The resident's blood sugar ranged from 79 - 139 on these 16 occasions but there was no site of injection or amount given documented on any of</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL092212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/12/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DUNMORE SENIOR LIVING OF ZEBULON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 W GANNON AVENUE</b> <b>ZEBULON, NC 27597</b>
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D 367	<p>Continued From page 23</p> <p>these 16 occasions.</p> <p>-The resident's blood sugar was 79 on 01/07/26 at 12:00pm and was documented as administered but should have been documented as held.</p> <p>-The resident's blood sugar was 115 on 01/14/26 at 9:00am and was documented as administered but should have been documented as held.</p> <p>-The resident's blood sugar was 116 on 01/19/26 at 9:00am and was documented as administered but should have been documented as held.</p> <p>-The resident's blood sugar ranged from 79 - 309 from 01/01/26 - 01/31/26.</p> <p>Review of Resident #5's February 2026 eMAR revealed:</p> <p>-There was an entry for Novolog insulin inject 3 units SQ 3 times daily with meals, hold for blood sugar &lt; 140.</p> <p>-Novolog insulin was scheduled to be administered at 9:00am, 12:00pm, and 5:00pm.</p> <p>-There was a row to document the site of the injection and a row to document the amount given.</p> <p>-Novolog insulin was documented as administered on 7 of 15 occasions when Resident #5's blood sugar was &lt; 140.</p> <p>-The resident's blood sugar ranged from 81 - 138 on these 7 occasions and there was no site of injection or amount given documented on 4 of these 7 occasions.</p> <p>-The resident's blood sugar was 81 on 02/12/26 at 9:00am and was documented as administered but should have been documented as held.</p> <p>-The resident's blood sugar was 116 on 02/16/26 at 9:00am and was documented as administered but should have been documented as held.</p> <p>-The resident's blood sugar was 130 on 02/08/26 at 9:00am and was documented as administered but should have been documented as held.</p>	D 367		

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D 367	<p>Continued From page 24</p> <p>-The resident's blood sugar was 138 on 02/07/26 at 9:00am and was documented as administered but should have been documented as held.</p> <p>-The resident's blood sugar ranged from 81 - 299 from 02/01/26 - 02/28/26.</p> <p>Review of Resident #5's March 2026 eMAR revealed:</p> <p>-There was an entry for Novolog insulin inject 3 units SQ 3 times daily with meals, hold for blood sugar &lt; 140.</p> <p>-Novolog insulin was scheduled to be administered at 9:00am, 12:00pm, and 5:00pm.</p> <p>-There was a row to document the site of the injection and a row to document the amount given.</p> <p>-The resident's blood sugar was 111 on 03/02/26 at 9:00am and 0 units were documented as administered but an injection site of the left side of the body was documented as if insulin was administered.</p> <p>-The resident's blood sugar was 137 on 03/05/26 at 12:00pm and 0 units were documented as administered but an injection site of the left side of the body was documented as if insulin was administered.</p> <p>-The resident's blood sugar ranged from 111 - 281 from 03/01/26 - 03/10/26.</p> <p>Observation of Resident #5's medications on hand on 03/11/26 at 11:39am revealed:</p> <p>-There was a box of Novolog insulin pens dispensed on 02/17/26.</p> <p>-There were 4 unopened Novolog insulin pens in the box.</p> <p>-The instructions on the medication label were to inject 3 units 3 times a day with meals for diabetes, if blood sugar is &lt; 140, do not give insulin.</p> <p>-There was one opened Novolog insulin pen in</p>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL092212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>03/12/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DUNMORE SENIOR LIVING OF ZEBULON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1205 W GANNON AVENUE ZEBULON, NC 27597</b>
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D 367	<p>Continued From page 25</p> <p>the medication cart that was documented as being opened on 03/03/26.</p> <p>Interview with Resident #5 on 03/11/26 at 10:49am revealed: -He usually received an insulin injection in his arm about once a day. -He thought his blood sugar was checked about 3 times a day. -He did not refuse insulin. -He did not think his insulin was held, they always gave insulin to him.</p> <p>Interview with a medication aide (MA) on 03/11/26 at 11:57am revealed: -If Resident #5's blood sugar was &lt; 140, she did not administer Novolog insulin to the resident. -If Resident #5's Novolog insulin was held, the MAs were supposed to document 0 units were administered on the eMAR and use the drop-down menu to document the insulin was not administered due to the resident's blood sugar being &lt; 140. -She did not know why she had documented Resident #5's insulin was administered when his blood sugar was &lt; 140. -She did not administer the insulin when Resident #5's blood sugar was &lt; 140; it was documentation errors.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 1:05pm revealed: -The MAs should use the drop-down box on the eMAR to show an exception when a medication was not administered. -The MAs should not document an injection site if no insulin was administered. -She was new as the RCC, and she did not currently have a system to review the eMARs for accuracy.</p>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL092212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>03/12/2026</b>
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D 367	Continued From page 26  Interview with the Administrator on 03/12/26 at 1:10pm revealed: -The MAs should not document Resident #5's Novolog insulin as administered on the eMAR if it was held. -The MAs should document exceptions on the eMAR when medication was not administered.	D 367		