Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092212	A. BUILDING: _____ B. WING _____	R 06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF ZEBULON	1205 W GANNON AVENUE ZEBULON, NC 27597

(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 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 06/17/26 - 06/18/26.	{D 000}	10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the medication cart was locked and all medications were maintained under locked security except when under the direct physical supervision of staff. The findings are: Review of the facility's medication policy and procedure dated September 2021 revealed: -Medications would be stored in a manner that ensured maintenance of both the integrity of the medication and the safety of all residents residing in the community. -All residents medications for residents who receive medication administration will be stored in the designated medication storage area (also identified as the "Medication Room"). -All medications would "always" be kept in locked	D 378	All Medication Aides and supervisory staff will receive mandatory re-education regarding the requirements of 10A NCAC 13F .1006 specifically, -Medication carts must remain locked whenever they are not under direct supervision. -Medications may not be left unattended or unsecured on top of medication carts or in resident care areas. -Staff must maintain direct visual supervision of the medication cart during medication administration rounds. Facility policy regarding medication storage and cart security was reviewed with all med aide staff Supervisors will conduct random medication pass observations/audits to ensure compliance with medication security practices. Any identified instances of non-compliance will result in immediate corrective action, additional education, and disciplinary action if warranted according to facility policy.	7/24/2026-ongoing Will be done monthly WP

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda J. Davis | TITLE: Adm | (X6) DATE: 7-14-26

REVIEWED AND ACKNOWLEDGED 07/14/26 BY NURSE CONSULTANT Janet B. Nielsen

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D 378	Continued From page 1 storage. Observation of the medication carts on 06/17/26 at 8:32 am revealed: -There were two medication carts observed positioned in the hallway outside the nurse's station with the push locks in the outward position indicating they were unlocked. -The Resident Care Coordinator (RCC) passed the medication carts and pushed the locks in on both medication carts to lock them. -There was a medication aide (MA) in the nurse's station with her back to the medication carts in the hallway. Observation of the medication cart on 06/17/26 at 1:25pm revealed: -The medication cart was locked and positioned in the hallway outside the dining room. -There was a resident labeled pharmacy dispensed medication package of Gabapentin (used to treat pain) 800mg tablet, quantity of 16 tablets, laying on top of the medication cart. -There was a second resident labeled pharmacy dispensed medication package for Gabapentin 200mg capsules, quantity of 13 doses, laying on top of the medication cart. -There was no medication aide (MA) supervising the medication cart. Observation of the MA on 06/17/26 at 1:25pm revealed she was standing inside the dining room with her back to the medication and next to a seated resident who was participating in a bingo activity. Interview with the MA on 06/17/26 at 1:28pm revealed: -She had removed the two Gabapentin medication packages out of the medication cart in	D 378		

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D 378	Continued From page 2 preparation for administration to the two residents. -She went in the dining room to see if the two residents were in the dining room playing bingo. -She would be able to see the medications laying on the top of the medication cart from inside the dining room if her back was not turned to the medication cart. -She knew she was not supposed to have left medications on the medication cart unsupervised. Second interview with the MA on 06/17/26 at 2:01pm revealed: -She thought the two residents whose Gabapentin medication packages were on the top of the medication cart, were in the dining room playing bingo. -The two residents were not in the dining room, so she had to go to the residents' rooms to administer their medication. -She never should have left any medications on the medication cart because it was not safe and anybody could walk by the medication cart and take the medications. -There were a couple of residents living in the facility who were confused and had dementia, and she did not know what the residents might be thinking. Interview with the Resident Care Coordinator (RCC) on 06/17/26 at 1:29pm revealed: -The medication carts were supposed to be locked, and the keys were supposed to be removed from the medication cart. -There should not be any medication containers on top of the medication cart. -The MAs were supposed to return the medication containers to the inside of the medication cart and lock the medication cart before leaving the medication cart.	D 378		

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D 378	Continued From page 3 -There should never be any medication containers left on top of the medication cart. -If she saw the keys left in the medication cart, she would remove the keys, lock the medication cart, and let the MAs know. -No medications were supposed to be left unsupervised on the medication cart because anybody could take the medications and it was a safety issue. Telephone interview with the contracted provider pharmacist on 06/18/26 at 9:58am revealed: -He did not like the sound of anything like medications laying out on the medication cart. -Gabapentin was a medication that had a bit of abuse potential. -Gabapentin had a similar affect as alcohol which included relaxing, impaired decision making, drowsiness, increased fall risk, and was a depressant. -He did not think Gabapentin should be left out and should be secured. Telephone interview with the Administrator on 06/18/26 at 11:00am revealed: -MAs were not to leave a medication cart unlocked. -MAs had been instructed not to leave medication carts unlocked or medications unattended because anybody could take the medications. -Gabapentin was used to treat pain. -Gabapentin could cause dizziness, sleepiness, and there could be a fall. -She expected the medication carts to be locked if the MA was not actively administering medication. -There were residents who walked around at the facility and were diagnosed with dementia.	D 378		