STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Margate Health and Rehab Center	540 Waugh Street Jefferson, NC 28640

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff, resident, manufacturer customer service representative, Pharmacy Manager and Nurse Practitioner interviews, the facility failed to protect a resident's right to be free from misappropriation of medication. This failure occurred for 1 of 1 resident reviewed for misappropriation. The findings included:Resident #24 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #24 was cognitively intact and had a diagnosis of diabetes mellitus.Review of Resident #24's physician orders revealed an order dated 09/11/25 for tirzepatide (Monjaro) 5 milligrams (mg) per 0.5 milliliters (ml) administer one syringe subcutaneously once a day on Friday for Type 2 Diabetes Mellitus.Review of a pharmacy delivery sheet dated 12/12/25 and signed by Nurse #4 at 10:00 PM indicated 2 ml of tirzepatide (which equals 4 injections) were delivered from the pharmacy for Resident #24.An interview was conducted with Nurse #4 on 02/11/26 at 12:16 PM who confirmed that she worked on the night of 12/12/25 and signed the pharmacy delivery sheet for Resident #24's tirzepatide pens. The Nurse stated the pens were delivered four in a pack and she put them in the locked box in the refrigerator as the facility treated the tirzepatide pens like the narcotics. The Nurse reported she looked at the pens closely to make sure they had medication in them before she locked them up. Nurse #4 reported that she did not know what happened to Resident #24's two tirzepatide pens that were discovered empty.Review of a pharmacy patient information insurance sheet dated 12/12/25 indicated 2 ml of tirzepatide (4 injections) were charged to Resident #24's insurance.Review of Resident #24's physician orders dated 12/13/25 revealed a verbal order given by the Nurse Practitioner on 12/13/25 at 11:00 AM for tirzepatide 5 mg/0.5 ml administer one syringe subcutaneously one time on 12/13/25.Review of Resident #24's Medication Administrator Record (MAR) for December 2025 revealed there was no documentation that Resident #24 received the tirzepatide injection on 12/12/25 by Nurse #1. There was documentation that the tirzepatide injection 5 mg/0.5 ml was given on 12/05/25 by Nurse #2, 12/13/25 by Nurse #2 and 12/19/25 by Nurse #5.An interview was conducted with Resident #24 on 02/08/26 at 12:17 PM. The Resident explained that about a month or so ago (12/12/25) a nurse (Nurse #1) went to administer Resident #24 her weekly Mounjaro (tirzepatide) injection, but the syringe was empty. The Resident continued to explain that the Nurse got another syringe from the refrigerator and that syringe was empty as well. The Resident stated she took the shots for her diabetes, and it helped her to lose weight. She continued to explain that she did get her weekly injection of Mounjaro, but it was two or three days late because they had to get it from the pharmacy. She reported that in the past (she could not remember when) she has had to wait for her Mounjaro shot to be delivered from the pharmacy which made getting the injection a day or so late, but she has never had the nurses attempt to give her the injection and the syringe be empty before that day (12/12/25).During an interview with Nurse #1 on 02/10/26 at 9:31 AM the Nurse explained that she worked on first shift on 12/12/25 and went to (continued on next page)

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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer the tirzepatide to Resident #24 using the pen she got from the refrigerator. She stated she tried to unlock the pen, but it was already unlocked and the purple cap was depressed. The pen was empty. She stated she informed the Wound Nurse and the Unit Manager, and they went to the medication room refrigerator, and discovered the other tirzepatide pen was the same way, it was empty. Nurse #1 continued to explain that she told Resident #24 that the pens were empty and they would get more medication from the pharmacy and she would get the injection the next day. The Nurse reported that she did not know what happened to the pens or why they would be empty.An interview was conducted at 3:50 PM on 02/09/26 with the Wound Nurse who explained that on 12/12/25 Nurse #1 approached her and asked her to look at the tirzepatide pen that belonged to Resident #24. She stated that Nurse #1 attempted to administer the medication to Resident #24 and could not get the medication to inject. After further inspection it was discovered, the pen had already been used because the purple cap was depressed and there was no medication in the pen. The Wound Nurse stated they went to report their finding to the Unit Manager and all three of them went to the medication room refrigerator where the tirzepatide pens were kept and discovered that both remaining pens were empty. The Wound Nurse reported she did not know why the two tirzepatide pens would be empty.An interview was conducted on 02/09/26 at 3:08 PM with the Unit Manager (UM) who was the acting Director of Nursing on 12/12/25. The UM explained that Resident #24 received weekly injections of tirzepatide on Fridays and on the morning of 12/12/25 around 8:00 AM, Nurse #1 went to administer the tirzepatide injection but could not get the lock mechanism on the syringe to unlock to inject the medication. Nurse #1 asked the Wound Nurse to assist her and the Wound Nurse discovered that the syringe had already been activated. The two nurses reported what they found to the Unit Manager who went to the medication room refrigerator to investigate the remaining tirzepatide syringe and discovered that the remaining syringe had been activated as well and both syringes were empty. She stated she determined that the syringes were empty by comparing them to another resident's tirzepatide prefilled syringe and the other resident's syringe did not have the purple cap depressed. The UM explained that after the medication had been injected the purple cap remained depressed which indicated the syringe was empty. The UM continued to explain that she reported the issue to the Administrator, the Regional Clinical Manager and informed the Nurse Practitioner (NP) of the issue, who gave her a verbal order to hold the medication for 12/12/25 until it was obtained from the pharmacy on 12/13/25. The UM reported that she called the pharmacy and discussed the issue with someone (she could not remember who) and reported that there were two syringes left and both syringes looked as if they were empty, but she could not determine why they were empty but Resident #24 needed her injections. She stated the pharmacy told her that they could send the medication with a new order. The UM stated she thought the facility paid for the medication. The UM stated that the NP also gave a verbal order to Nurse #2 on 12/13/25 to give the tirzepatide on 12/13/25 and the medication was given on 12/13/25 by Nurse #2. The Unit Manager stated she did not think about misappropriation of medication because she was new to the position and the only thing on her mind was what she could do to prevent it from happening again.Interviews were conducted with Nurse #2 on 02/08/26 at 12:30 PM and 02/11/26 at 9:30 AM. The Nurse explained that she worked first shift on 12/13/25 and received a verbal order from the Nurse Practitioner to administer tirzepatide 5 mg per 0.5 ml subcutaneously to Resident #24. The Nurse stated she gave it at 11:37 AM on 12/13/25. The Nurse reported that she gave Resident #24 the tirzepatide on 12/05/25 and did not encounter an empty pen when administering the injection. Nurse #2 stated she did not know what happened to the two tirzepatide pens that belonged to Resident #24.Observations were made of the two tirzepatide pens on 02/09/26 at 3:08 PM and 02/11/26 at 11:25 AM along with the Unit Manager. The pens appeared to (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be empty, the purple caps were depressed, and the plungers were visible, indicating the medication had been injected or expressed from the pen.On 02/10/26 at 9:53 AM and 02/11/26 at 1:23 PM interviews were conducted with the Pharmacy Manager who explained that on 12/12/25 they received a call from the Unit Manager who stated the last two tirzepatide pens belonging to Resident #24 were empty and they needed a refill. The Pharmacy Manager told the Unit Manager that the pharmacy would need an order before the pharmacy could refill the medication. Soon after that the Nurse Practitioner called the pharmacy (12/12/25) and gave them an order for a refill of the tirzepatide for Resident #24. The Pharmacy Manager explained that the Resident's insurance paid for the medication which was $285.79 per pen. She stated the insurance would occasionally refill a prescription early but not always, but in this case they did. She stated if the insurance company did not agree to pay for the early refill, then the facility would have had to pay for it. The Pharmacy Manager stated they received the tirzepatide injections in a box from the manufacturer, and it was possible for them to be damaged or empty, but the pharmacy would discover any damage before they sent them to the facilities because they had to label and package each pen. The Pharmacy Manager could not provide any specific details about damaged or empty pens. She stated she would expect the facility to report damaged or empty insulin pens to the pharmacy as soon as possible.An interview was conducted with Nurse #3 on 02/10/26 at 10:12 AM. The Nurse stated she received Resident #24's tirzepatide pens from the pharmacy on the night of 11/21/25 and put the pens in the refrigerator as the normal procedure. She stated she usually did not inspect the pens to determine whether they were full, but she did not after 12/12/25 because they treated the pens like narcotics and locked them in the refrigerator. Nurse #3 stated she did not know why the two tirzepatide pens were empty on 12/12/25.During an interview with Nurse #5 on 02/11/26 at 11:00 AM the Nurse reported she gave Resident #24 her tirzepatide injection on 12/19/25. She stated she did not know what happened to the two tirzepatide pens or why they would be empty on 12/12/25. On 02/11/26 at 12:00 PM an interview was conducted with a representative from the tirzepatide manufacturer who explained that the tirzepatide pens were supplied to the pharmacy in a box of four pens and it was possible that the pens could leak but the pharmacy would notice they leaked when repacking the pens.An interview was conducted with the Nurse Practitioner on 02/10/26 at 3:35 PM who explained that the Unit Manager reported to him on 12/12/25 that Nurse #1 went to give Resident #24 her tirzepatide and the pen was empty then when they went to use the other pen, they discovered that the other pen was empty as well. The Nurse Practitioner stated he called the pharmacy and gave them an order to refill the prescription, and they sent the medication the next day and Resident #24 received the medication. The Nurse Practitioner stated the facility was going to investigate the empty pens, but he did not know the outcome.On 02/11/26 at 9:00 AM an interview was conducted with the Regional Clinical Manager who explained that the Unit Manager called her on 12/12/25 when the empty tirzepatide pens were discovered. She reported that the Unit Manager did not know how the pens were emptied but because they were expensive and highly sought after she wanted to lock them up and treat them like narcotics, which she thought was a good idea because they do that in other buildings. The Regional Clinical Manager stated she thought about why the tirzepatide pens were empty and concluded it could be human error or misappropriation but more so human error.On 02/11/26 at 3:19 PM an interview was conducted with the Administrator who explained that she was notified by phone on 12/12/25 by the Unit Manager about the empty tirzepatide pens but she did not go into detail. The Unit Manager was going to investigate the issue and notify the Nurse Practitioner to get an order for more medication and then notify the Regional Clinical Manager. The Administrator stated she should have been more diligent in the investigation to determine how the pens were emptied but she did not. The (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated she did not think about misappropriation of medications because if she did, she would have reported it.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to implement their abuse policy in the areas of reporting and investigating an allegation of misappropriation. Upon the discovery of misappropriation, the facility did not submit a report to the State Agency or conduct a thorough investigation of the misappropriation. This failure occurred for 1 of 1 resident reviewed for misappropriation (Resident #24).The findings included:The facility's policy titled, Abuse, Neglect and Exploitation, revised 06/01/25 read in part, It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent . and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. The facility will implement policies and procedures to prevent and prohibit all types of abuse to include misappropriation of resident property. V. Investigation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. VII. Reporting: The facility will have written procedures that include reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies e.g., law enforcement when applicable within specified timeframes.Resident #24 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #24 was cognitively intact.Review of Resident #24's physician orders revealed an order dated 09/11/25 for tirzepatide (Monjaro) 5 milligrams (mg) per 0.5 milliliters (ml) administer one syringe subcutaneously once a day on Friday for Type 2 Diabetes Mellitus.On 02/08/26 at 12:17 PM and interview was conducted with Resident #24. The Resident reported that about a month ago (12/12/25) a nurse (Nurse #1) went to administer her weekly Mounjaro (tirzepatide) injection that she took for her diabetes, which helped her lose weight, but the syringe was empty. She explained that the Nurse returned with another syringe from the refrigerator and that syringe was empty as well. Resident #24 stated that she did receive her weekly injection of Mounjaro, but it was two or three days late because they had to get it from the pharmacy. She reported that she has never had the nurses attempt to give her the injection and the syringe be empty before that day (12/12/25).An interview was conducted with Nurse #1 on 02/10/26 at 9:31 AM. The Nurse reported that she worked on first shift on 12/12/25 and went to administer the tirzepatide to Resident #24 using the pen she got from the refrigerator. She stated she tried to unlock the pen, but it was already unlocked and the purple cap was depressed signifying the pen was empty. The Nurse stated she notified the Unit Manager that the pen was empty, and they went to the medication room refrigerator to discover that the last remaining tirzepatide pen belonging to Resident #24 was empty as well. Nurse #1 stated she explained to Resident #24 that the pens were empty, and they would get more medication from the pharmacy, and she would get the injection the next day.On 02/09/26 at 3:08 PM an interview was conducted with the Unit Manager (UM) who was the acting Director of Nursing on 12/12/25. The UM explained that Resident #24 received weekly injections of tirzepatide on Fridays and on the morning of 12/12/25, Nurse #1 informed her that she went to administer the tirzepatide injection to Resident #24 but could not get the lock mechanism on the syringe to unlock to inject the medication. It was discovered that the syringe had already been used. The Unit Manager stated they went to the medication room refrigerator to investigate the remaining tirzepatide syringe and discovered that the remaining syringe had been activated as well and both syringes were empty. She stated she determined that the two syringes were empty by comparing them to another (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's tirzepatide prefilled syringe and the other resident's syringe did not have the purple cap depressed. The UM explained that after the medication had been injected the purple cap remained depressed which indicated the syringe was empty. The UM continued to explain that she reported the issue to the Administrator, the Regional Clinical Manager and informed the Nurse Practitioner (NP) of the issue, who gave her a verbal order to hold the medication for 12/12/25 until it was obtained from the pharmacy on 12/13/25. The UM reported that she called the pharmacy and discussed the issue with someone (she could not remember who) and reported that there were two syringes left and both syringes looked as if they were empty, but she could not determine why the syringes were empty and Resident #24 needed her injections. She stated the pharmacy told her that they could send the medication with a new order which she obtained from the Nurse Practitioner and the tirzepatide injection was given to Resident #24 on 12/13/25. The Unit Manager stated she did not think about misappropriation of medication or to investigate about what happened or why the tirzepatide syringes were empty because she was new to the position and the only thing on her mind was what she could do to prevent it from happening again.During an interview with the Administrator on 02/11/26 at 3:19 PM the Administrator explained that she was notified on 12/12/25 by the Unit Manager via telephone about the empty tirzepatide pens but the Unit Manager did not go into detail, nor did the Administrator think to ask for the details. She stated she thought the Unit Manager was going to investigate the issue. The Administrator stated she should have been more diligent in the investigation to determine how the pens were emptied but she did not. The Administrator stated she did not think about misappropriation of medications because if she had thought about it, she knew she had to report misappropriation and she would have reported it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews and staff interviews, the facility failed to follow their Hand Hygiene Policy when the Wound Nurse performed pressure ulcer treatments on Resident #10 and did not wash or sanitize her hands before applying clean gloves. This deficient practice occurred for 1 of 7 staff members observed for infection control practices (Wound Nurse).The findings included:Review of the facility's Hand Hygiene policy read in part:All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.Review of the facility's Basics of Hand Hygiene policy read in part:You should always perform hand hygiene: before applying and after removing personal protective equipment (e.g., gloves), before and after providing any type of care and after contact with bodily fluids or other potentially contaminated surfaces.Wound care observations were made on 02/10/26 at 2:15 PM on Resident #10 by the Wound Nurse. The Wound Nurse gathered the supplies and placed them on an over bed table that had been disinfected and a protective barrier had been placed on the table. The Wound Nurse washed her hands and applied a gown and gloves for the procedure. The Resident had been positioned on her right hip exposing her left hip wound where the Wound Nurse removed the dirty dressing, removed her gloves and applied clean gloves without performing hand hygiene. The Wound Nurse then cleansed the wound with a cleansing solution and applied skin prep. The Wound Nurse removed her gloves, sanitized her hands and applied clean gloves before she applied a foam dressing to the wound. The Wound Nurse then removed her gloves but did not perform hand hygiene before she applied clean gloves. Resident #10 was then positioned on her left side to expose wounds on her sacrum and right hip. The Wound Nurse then removed the dirty dressing from Resident #10's sacrum, removed her dirty gloves and performed hand hygiene before she applied clean gloves. She then cleansed the wound with a wound cleanser and removed her dirty gloves and without performing hand hygiene the Wound Nurse applied clean gloves and applied a soaked gauze and covered the gauze with a foam dressing then removed her gloves and performed hand hygiene before she applied clean gloves. The Wound Nurse then removed the dirty dressing from Resident #10 right hip and removed her dirty gloves then she washed her hands before she applied clean gloves. She then cleansed the wound with a wound cleanser and removed her dirty gloves and applied clean gloves without performing hand hygiene. The Wound Nurse then applied a soaked gauze to the wound and covered it with a foam dressing and removed her gloves and performed hand hygiene.Interviews were conducted with the Wound Nurse on 02/10/26 at 2:50 PM and 02/11/26 at 10:40 AM. The Wound Nurse stated that she did not realize that she did not wash or sanitize her hands each time after she removed dirty gloves and before she applied clean gloves and stated that she knew that she was supposed to. She stated that she had to change gloves numerous times during Resident #10's treatment that she must have lost track, and she was nervous being watched.During an interview with the Infection Preventionist (IP) on 02/13/26 at 10:35 AM the IP indicated that according to the facility's policy and standard practice of handwashing the Wound Nurse should have washed or sanitized her hands every time she removed her gloves whether they were visibly soiled or not.An interview was conducted with the Administrator on 02/11/26 at 3:30 PM. The Administrator explained that she had been made aware of the Wound Nurse not washing or sanitizing her hands between glove changes and the Wound Nurse told her she was nervous. The Administrator stated she had not heard of any problems with the Wound Nurse's wound treatment technique of not washing her hands after removing dirty gloves and before applying clean gloves previously. The Administrator indicated her expectation was that the Wound Nurse perform the treatments according to the professional standards of wound care and handwashing.