STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345515**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PruittHealth-Town Center	**6300 Roberta Road , Harrisburg, North Carolina, 28075**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/25/2025 through 8/28/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D450B-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/25/2025 through 8/28/2025. Event ID ID450B-H1. The following intakes were investigated 808466, 808461, 808459, and 808458. 3 of the 5 allegations resulted in deficiency. The 2567 was amended on 9/26/25 to reflect changes as result of Informal Dispute Resolution (IDR).	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F0580		

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

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

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F0580 SS = D	Continued from page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Physician and staff interviews, the facility staff failed to notify the physician when 70/30 Insulin (type of insulin used to control blood sugar by providing both immediate and extended insulin action) was not administered or administered late for 1 of 1 resident reviewed for notification (Resident #82). The findings included: Resident #82 was admitted to the facility on 8/20/25 with diagnoses that included diabetes. Resident #82's physician orders included an order dated 8/20/25 for Humulin 70/30 insulin 90 units to be given at 8:00AM and 5:00PM with blood sugar checks taken before.	F0580		

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F0580 SS = D	Continued from page 2 The August 2025 Medication Administration Record (MAR) for Resident #82 revealed Humulin 70/30 was administered late and not administered on the following dates and times with associated blood sugar values (normal blood sugar levels are between 70 and 99): -On 8/22/25 the ordered 8:00AM Humulin 70/30 90-unit dose was administered at 12:19PM with a recorded blood sugar of 405. The MAR comment specified “Administered late”. -On 8/24/25 the ordered 5:00PM Humulin 70/30 90-unit dose was not administered with a recorded blood sugar of 420. The MAR comment specified, “waiting to receive from pharmacy”. -On 8/25/25 the ordered 8:00AM Humulin 70/30 90-unit dose was administered at 10:13AM with a recorded blood sugar of 549. The MAR comment specified, “Administered late”. Nurse #6 was interviewed on 8/27/25 at 10:27AM. Nurse #6 revealed that she was assigned to Resident #82 on 8/22/25 during day shift and 8/25/25 during day shift, and she administered Resident #82’s 8:00AM 70/30 insulin dose about two hours late. Nurse #6 stated she administered medications to residents in numerical room order, which caused Resident #82 70/30 insulin to be administered late. An Interview was conducted with Nurse #8 on 8/28/25 at 11:02AM which revealed Nurse #8 was assigned to Resident #82 on 8/24/25. Nurse #8 stated she administered Resident #82 last dose of 70/30 insulin on 8/24/25 before breakfast. Nurse #8 called the pharmacy after morning medication administration to order additional 70/30 insulin for Resident #82. Nurse #8 stated the pharmacy had not delivered the 70/30 insulin for Resident #82 in time for the 8/24/25 5:00pm medication administration so the 70/30 insulin was not administered. Nurse #8 stated she did not call the physician to inform him Resident #82 missed her 5:00PM dose of 70/30 insulin but stated she should have informed the Physician The Director of Nursing (DON) was interviewed on 8/28/25 at 9:32AM and stated insulin should be given within the window of time of 2 hours, 1 hour before or after a meal and expects nurses to inform leadership if medications are not given on time.	F0580		

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F0580 SS = D	Continued from page 3 A follow-up interview was conducted with the Director of Nursing (DON) on 8/28/25 at 12:07PM that revealed the DON expected nurses to inform the physician if a dose of insulin was not administered. The Physician was interviewed on 8/28/25 at 9:24AM. The Physician indicated it would not be acceptable practice to administer 70-30 insulin after breakfast, and he would expect nursing to inform him if 70/30 insulin was administered two hours late, after breakfast. An additional interview with the Physician on 8/28/25 at 2:03PM revealed the Physician was not notified that the 70/30 insulin dose on 8/24/25 was not administered, and that he expected a missing dose of 70/30 insulin would have been called to him immediately.	F0580		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of controlled opioid pain medication by staff. This affected 1 of 3 residents reviewed for misappropriation of property (Resident #75). The findings included: Resident #75 was admitted to the facility on 9/10/2024 with diagnoses including lumbar stenosis with lumbar fusion (a procedures for severe lumbar spinal stenosis, a condition where the spinal canal in the lower back narrows, compressing nerves). Resident #75 discharged home on 9/25/2024.	F0602		

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F0602 SS = D	Continued from page 4 Resident #75 physician orders dated for 9/10/2024 revealed an order for Oxycodone 5 milligrams (mg) one (1) tablet every 4 hours as needed for moderate pain on a pain scale of 4-6. Resident #75 Minimal Data Set (MDS) dated 9/14/2024 revealed resident was cognitively intact. Resident #75 was coded as receiving opioids and also on a scheduled pain regimen. A review of the Initial Allegation Report completed by the previous Director of Nursing (DON) revealed on 9/16/2024 Resident #75 alleged she had not received her morning pain medication on 9/16/2024 at 6:30 AM. The confirmation sheet for the fax of the Initial Allegation Report indicated the report was submitted to the state on 9/18/24 at 3:27 PM by the previous DON. Review of the Investigation Report dated 9/27/2024 revealed the facility's investigation determined Nurse #9 misappropriated Resident #75's oxycodone and was terminated. The Investigation Report further revealed Nurse #9 admitted to diverting (2) Oxycodone 5mg tablets and was reported to the NC Board of Nursing. A review of Resident #75's controlled drug record for Oxycodone tab 5mg one (1) tab by mouth every 4 hours as needed for pain revealed Nurse #9 signed out four (4) doses of Oxycodone 5mg on 9/16/2024. The times documented on the controlled drug record by Nurse #9 were 12:13 AM, 2:10 AM, 3:46 AM, and 6:30 AM. A review of the Medication Administration Record (MAR) revealed Nurse #9 did not document administration of pain medication Oxycodone 5mg to Resident #75 on 9/15/2024 or 9/16/2024. A telephone interview was conducted with Resident #75 on 8/28/2025 at 9:20 AM. Resident #75 was able to recall not receiving her pain medications as requested on 9/16/2024. Resident #75 reported she did not receive all her pain medication during night shift (7:00 PM on 9/15/2024 through 7:00 AM on 9/16/2024) from Nurse #9. Resident #75 stated she requested pain medication in the early morning but was unable to recall the exact time of the request. Resident #75 indicated she was told that she had received the allotted amount and was	F0602		

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F0602 SS = D	Continued from page 5 not able to have any additional pain medication. Resident #75 further stated she only received 2 doses of the 4 doses she was allowed to receive during the 7:00 PM to 7:00 AM shift. A telephone interview was conducted with the previous DON on 8/27/2025 at 2:07 PM. The DON confirmed that she spoke directly to the accused Nurse (Nurse #9) on 9/18/2024 regarding the allegation of misappropriation of Resident #75's medication. The DON indicated that the accused Nurse (Nurse #9) admitted to using Resident #75's Oxycodone 5mg for personal use. Nurse #9 confirmed she diverted (2) Oxycodone 5mg tablets from Resident #75. The DON stated she reported Nurse #9 to the NC Board of Nursing on 9/18/2024. On 8/27/2025 at 11:24 AM a telephone interview was attempted with Nurse #9 and the telephone number had been restricted. A telephone interview was conducted with the previous Administrator on 8/28/2025 at 9:28 AM. The previous Administrator was unable to recall the entire event, but was able to verify she was notified, and the accused Nurse (Nurse #9) was terminated for misappropriation. The previous Administrator verified there was education during the investigation on misappropriation and monitoring of any other residents potentially affected. She further indicated there were no other residents impacted.	F0602		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to	F0609		

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F0609 SS = D	Continued from page 6 the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of physical abuse to law enforcement and adult protective services (APS) for Resident #10 and report an allegation of misappropriation of medication to the State Survey Agency and local law enforcement within the required time frame and did not report the allegation to adult protective services and for Resident #75. The deficient practice occurred for 2 of 4 residents reviewed for reporting of abuse allegations (Resident #10 and Resident #75). The findings included: 1.Resident #10 was re-admitted to the facility on 7/18/2024. Review of the Initial Allegation report dated 10/17/2024 and completed by the previous Director of Nursing (DON), and containing the name of the current Administrator, revealed Resident #10 reported “that a man had come to his room the other night and beat him.” The allegation was reported to the DON on 10/17/2024 at 2:00 PM. The State Agency was notified via fax on 10/17/2024 at 2:19 PM. The section of the form that asks if the incident was reported to law enforcement was blank. The facility was unable to show any police report or other documentation indicating that law enforcement and Adult Protective Services (APS) had been contacted by the facility. The Investigation Report dated 10/24/2024 and completed by the previous DON, revealed the abuse allegation was not substantiated. The sections of the form related to notification of APS and Law Enforcement were blank.	F0609		

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F0609 SS = D	Continued from page 7 During an interview on 08/28/2025 at 1:45 PM, the Administrator indicated he did not recall this incident. He stated he did not make any reports to law enforcement or APS and was not aware of any police reports or documentation that APS had been notified. He stated that abuse allegations were to be reported immediately by the Administrator, DON, or Social Worker to Law Enforcement and APS and this reporting would be reflected on the Initial Allegation or Investigation Report indicating when the notification was made. A telephone interview on 8/28/2025 at 3:30 PM with the previous Director of Nursing (DON) confirmed she recalled the allegation made by Resident #10. She stated that she had submitted the investigation reports via fax to the State Agency and conducted the investigation into the alleged abuse incident. She revealed the facility process had been the Administrator was responsible for calling Law Enforcement, and the Social Worker reported to APS. She herself did not make reports to Law Enforcement or APS and was unaware whether the Administrator had called Law Enforcement or if the previous Social Worker had contacted APS. She further explained that if she had reported to Law Enforcement or APS, she would have indicated it on the State reporting forms. Attempts to contact the previous Social Worker by telephone were unsuccessful. The DON was interviewed 8/28/2025 at 1:40 PM. She stated she was not the DON when the incident with Resident #10 occurred and had no knowledge of what had been reported at that time. She said that everyone received education on abuse and neglect and reporting during the new hire orientation and when there was an allegation of abuse. Staff received at the minimum annual training whether there was an allegation or not. She confirmed that it was a requirement to report abuse allegations to the State Agency, law enforcement, and Adult Protective Services. 2.Resident #75 was admitted to the facility on 9/10/2024 and was discharged from the facility on 9/25/2024. A review of the Initial Allegation Report completed by the previous Director of Nursing (DON) revealed on	F0609		

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F0609 SS = D	Continued from page 8 9/16/2024 Resident #75 alleged she had not received her morning pain medication on 9/16/2024 at 6:30 AM. The confirmation sheet for the fax of the Initial Allegation Report indicated the report was submitted to the state on 9/18/24 at 3:27 PM by the previous DON. Local law enforcement was notified of the allegation on 9/18/2024 at 2:06 PM. Notification of Adult Protective Services was not documented in the Initial Allegation Report. Review of the Investigation Report dated 9/27/2024 revealed the facility's investigation determined Nurse #9 misappropriated Resident #75's oxycodone and was terminated. Notification of APS was not documented in the Investigation Report. A telephone interview with previous Administrator on 8/28/2025 at 9:28 AM revealed she recalled Resident #75's allegation of misappropriation. The previous Administrator stated Local Law Enforcement and Adult Protective Services should have been contacted and did not know why they were not. The previous Administrator confirmed that the previous Director of Nursing completed the Initial Allegation report for the misappropriation allegation. The previous Administrator confirmed that Law Enforcement was called regarding misappropriation for Resident #75, but this was not completed timely. A telephone interview with the previous DON on 8/28/2025 at 2:07 PM revealed she confirmed she sent the Initial Allegation report via fax to the State Agency after receiving the misappropriation allegation from Resident #75. The previous DON was unable to recall the exact date the Initial Allegation report was sent. She stated it was the Administrators responsibility to notify Local Law Enforcement and did not know why Adult Protective Service was not notified. The DON further stated she was not responsible for calling Law Enforcement and the Social Service Director (SSD) was responsible for calling Adult Protective Services. The previous DON indicated she could not recall the regulatory requirements with required time frames for reporting allegations of abuse/misappropriations. The previous SSD was unable to be contacted during the investigation.	F0609		

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F0609 SS = D	Continued from page 9 An interview was conducted with the current Administrator on 8/28/2025 at 1:27 PM, revealed allegations of misappropriation required immediate notification of the allegation within 2 hours to the State Agency, Local Law Enforcement, and Adult Protective Services. The Regional Nurse Consultant stated on 8/28/2025 at 1:27 PM, regardless of the resident's cognitive status any allegations of abuse and/or misappropriation would be reported to the Administrator, the State Licensure Office, Local Law Enforcement, and to Adult Protective Services. The Regional Nurse Consultant further stated this was the company procedure currently and she was also notified of any allegations.	F0609		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and physician, resident and staff interviews, the facility failed to administer 70/30 Insulin (type of insulin used to control blood sugar by providing both immediate and extended insulin action) and failed to adhere to administration times as ordered by the physician for 1 of 1 resident reviewed for significant medication errors (Resident #82). The findings included: Resident # 82 was admitted to the facility on 8/20/25 with diagnoses that included diabetes and hypertension. Resident #82 physician orders included an order dated 8/20/25 for Humulin 70/30 insulin 90 units to be given at 8:00AM and 5:00PM with blood sugars taken before. Resident #82's admission Minimum Data Set (MDS) was in progress. Resident #82's care plan dated 8/22/25 revealed Resident #82 had a goal to maintain appropriate blood glucose levels and Resident #82 would not have diabetic distress that will require hospital stay through next review period. Resident #82 interventions included:	F0760		

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F0760 SS = D	Continued from page 10	F0760		

- Monitor blood glucose as ordered

- Monitor for signs of hyperglycemia (high blood sugar); blood glucose > 140mg/dl; increased thirst; increased urination; increased appetite followed by lack of appetite; nausea, vomiting.

- Monitor for signs of hypoglycemia (low blood sugar); blood glucose < 60mg/dl; sweating; cold, clammy skin; numbness of fingers, toes, mouth; rapid heartbeat; nervousness, tremors; faintness, dizziness.

-Notify MD of abnormal results.

A record review of Resident #82 labs revealed on 8/22/25 Resident #82 had a hemoglobin A1c test result of 11% (average amount of sugar in your blood over the past two to three months. Lower than 5.7% in normal range, 5.7% to 6.4% indicates prediabetes, and greater than 6.4% indicates diabetes).

A Nurse Practitioner assessment dated 8/25/25 indicted Resident #82's mental status was alert and behavior was cooperative.

The August 2025 Medication Administration Record (MAR) for Resident #82 revealed Humulin 70/30 was administered late or not administered on the following dates and times with associated blood sugars (BS) values (normal blood sugar levels are between 70 and 99):

-On 8/22/25 the ordered 8:00AM Humulin 70/30 90-unit dose was administered at 12:19PM with a recorded BS of 405.

-On 8/24/25 the ordered 5:00PM Humulin 70/30 90-unit dose was not administered with a recorded BS of 420. The MAR comment specified, "waiting to receive from pharmacy".

-On 8/25/25 the ordered 8:00AM Humulin 70/30 90-unit dose was administered at 10:13AM with a recorded BS of 549.

An observation of Resident #82 on 8/25/25 at 1:34PM revealed Resident #82 displayed no signs or symptoms of high blood sugar (nausea, vomiting, confusion, or abdominal pain).

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NAME OF PROVIDER OR SUPPLIER **PruittHealth-Town Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **6300 Roberta Road , Harrisburg, North Carolina, 28075**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0760 SS = D	Continued from page 11 On 8/26/25 at 10:26AM, an interview occurred with Resident #82 that revealed on 8/22/25 Family Member #1 complained to the facility on Resident #82's behalf that she had not received her 70/30 insulin before meals. An interview was conducted with Nurse #8 on 8/28/25 at 11:02AM which revealed Nurse #8 was assigned to Resident #82 on 8/24/25. Nurse #8 stated she administered Resident #82's last dose of 70/30 insulin on 8/24/25 before breakfast. Nurse #8 called the pharmacy after morning medication administration to order additional 70/30 insulin for Resident #82. Nurse #8 stated the pharmacy had not delivered the 70/30 insulin for Resident #82 in time for the 8/24/25 5:00pm medication administration. Nurse #6 was interviewed on 8/27/25 at 10:27AM. Nurse #6 revealed that she was assigned to Resident #82 on 8/25/25 during the day shift, and she administered Resident #82's 8:00AM 70/30 insulin dose about two hours late. Nurse #6 stated she administered medications to residents in numerical room order, which caused Resident# 82 70/30 insulin to be administered late. The physician was interviewed on 8/28/25 at 9:24AM. The physician indicated it would not be acceptable practice to administer 70-30 insulin after breakfast, and he would expect nursing to inform him if 70/30 insulin was administered two hours late, after breakfast. The physician also stated he was not notified that the 70/30 insulin dose on 8/24/25 was not administered, and that he expected a missing dose of 70/30 insulin would have been called to him immediately. An interview was conducted with the Director of Nursing (DON) on 8/28/25 at 9:32AM. The DON stated that 70/30 insulin would be given within the window of time of two hours, one hour before or after a meal. The DON stated they do not have Humulin 70/30 in the facility as back up. The DON stated Nurse #8 called the pharmacy after the morning med pass to order more Humulin 70/30 and Nurse #8 gave Novolog sliding scale insulin on 08/24/25 at 5:00PM, which was also ordered for Resident 82. The DON stated nurses should inform leadership if medications were not given on time.	F0760		