

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Pruitthealth-Town Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6300 Roberta Road Harrisburg, NC 28075	

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. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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. 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 [DATE] 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 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.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:</p> <p>1. Resident #10 was re-admitted to the facility on [DATE].</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Attempts to contact the previous Social Worker by telephone were unsuccessful.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>2.Resident #75 was admitted to the facility on [DATE] and was discharged from the facility on 9/25/2024.</p> <p>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. 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The previous SSD was unable to be contacted during the investigation.</p> <p>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.</p> <p>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.</p>		