STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Carolina Point		STREET ADDRESS, CITY, STATE, ZIP CODE 5935 Mount Sinai Road Durham, NC 27705	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and interview of the staff and Police Officer #1, the facility failed to protect a cognitively impaired dependent resident (Resident #1) from sexual abuse by a cognitively intact resident (Resident #2). On 3/19/24 Resident #2 was found in Resident #1's room by Nursing Assistant #1. Resident #2 was observed fondling Resident #1's penis with skin to skin contact from his hand. Resident #1 was unable to stop the sexual abuse due to his limited ability to move and he was non-verbal/unable to call for help. Resident #1 was incapable of consenting to the sexual act and could not express an adverse psychosocial outcome. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause emotional trauma. This deficient practice affected 1 of 3 residents reviewed for abuse. Immediate Jeopardy began on 3/19/24 when staff failed to protect Resident #1 from sexual abuse. Immediate jeopardy was removed on 4/10/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure staff education is completed and monitoring systems put into place are effective. Findings included: A. Resident #1 was admitted to the facility on [DATE] with the diagnoses of quadriplegia (paralysis of the body below the neck) after skull fracture, Traumatic Brain Injury (TBI), aphasia (loss of ability to understand or express speech). Resident #1's quarterly Minimum Data Set, dated dated dated [DATE] indicated the resident was rarely/never understood. The resident had functional limitations in range of motion of his bilateral upper and lower extremities and was dependent on assistance with all activities of daily living. B. Resident #2's hospital discharge summary dated 2/20/24 documented the resident was homeless living in a shelter and had fallen due to advancing Parkinson's disease. The resident had significant risk for worsening of his medical and behavioral status and was at high risk for rehospitalization . Resident #2 was admitted to the facility on [DATE] with the diagnosis of Parkinson's disease. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's admission Minimum Data Set, dated dated dated [DATE] documented he had an intact cognition and no behaviors. The resident used a walker and a wheelchair for ambulation and was independent with set up. A nurse's note at 9:00 pm on 03/09/24 documented Resident #2 informed the Interim Director of Nursing that he was taking a cab to visit his sister who had just come to town. The Interim Director of Nursing informed the resident that it was late, and he should wait until tomorrow to visit. The resident stated, I'm not waiting until tomorrow, she already called my cab and it's upfront waiting for me. The resident proceeded to the front door where he was observed getting into a van. The resident refused to sign out. The resident was in no apparent distress at the time of departure from the facility. The resident's emergency contact was called. The person answering the phone commented that they had the wrong number. Resident #2's Emergency Department record dated 3/10/24 documented he was seen for leg and foot pain. The resident had a positive drug screen for cocaine. The facility allowed him to return to the facility on [DATE] and he was discharged from the hospital. The Interim Director of Nursing documented in the nurses' notes on 3/19/24 Resident #2 was observed by staff with inappropriate touching of Resident #1's private part. The resident was immediately separated and placed on one-to-one supervision in a room by himself. Resident #2 was interviewed, and he informed the Interim Director of Nursing he touched Resident #1's private part. Resident #2 also indicated that this was the first time he did anything like this here. On 4/4/24 at 2:12 pm an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated she was assigned to Residents #1 and #2 on 3/19/24 during the abuse incident. During rounds shortly after the evening shift change, NA #1 entered Resident #1's room and observed Resident #1 lying in his bed near the door and Resident #2 was in his wheelchair sitting by the side of Resident #1's bed with his back to the door. The door was open. Resident #1's disposable undergarment was open and hospital gown in place, his (Resident #1's) penis was exposed, and Resident #2 had Resident #1's penis in his hand and was fondling it with one hand. She indicated Resident #1 was not saying anything or using his hands to stop Resident #2 during the incident. Resident #1's eyes were open. NA #1 stated she asked Resident #2 what he was doing, and Resident #2 commented Resident #1 told him he would pay him $3 to touch him. NA #1 informed Resident #2 that Resident #1 cannot speak and to get out of the room. Resident #2 was escorted out of the resident's room by NA #1 and placed on one-to-one supervision by another nursing assistant. NA #1 stated she had not known how long Resident #2 was in Resident #1's room or how long he (Resident #2) was touching his (Resident #1's) genitals. NA #1 further stated she was not familiar with Resident #2. He was a new admit for rehabilitation. NA #1 stated there appeared to be no harm to Resident #1 and she immediately reported the incident to the supervising nurse (Nurse #1). Resident #2 left the facility Against Medical Advice (AMA) after the incident the next day. Resident #1 was sent to the hospital for evaluation and transferred to another facility. NA #1 stated this was the first time she had observed Resident #1 in his room on her shift 3/19/24. Resident #2 was from another hall and not on her assignment. Their rooms were not close to each other, they resided on different halls (200 and 300). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/4/24 at 3:25 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 3/19/24 during the evening shift and was informed of the sexual abuse by NA #1. Nurse #1 stated she was informed that Resident #2 was observed by NA #1 molesting/holding the penis of Resident #1. Resident #2 was immediately removed from Resident #1's room by NA #1 and Nurse #1 observed Resident #2 in his room alone with one-to-one supervision by the nursing assistant. Nurse #1 stated she immediately informed the Administrator, and an investigation began. Resident #1 was examined by Nurse #1, and no injury was observed. Resident #1 was sent to the emergency room and the family were notified. Resident #2 was a new admit and there was no prior behavior of this type. The Resident #1 was oriented to self and situation and was non-verbal. On 4/8/24 at 1:46 pm an interview was conducted with Police Officer #1 from the Special Crime Victims Unit by phone. The Officer stated Resident #2 (perpetrator) admitted to sexual abuse Resident #1 when interviewed by the responding Officer. Officer #1 stated she tried to interview Resident #1 (victim) at another facility on 4/8/24 by using yes and no questions raising his hand. Resident #1 had limited participation and was non-verbal. Police Officer #1 further stated since the sexual abuse was observed by facility staff and Resident #2 admitted to the crime, the case will be presented to the District Attorney for prosecution. The whereabouts of Resident #2 were currently unknown. Police Officer #1 indicated she had just completed her investigation on 4/8/24 and there was no report completed at this time. Resident #2's nurse's note completed by the Interim Director of Nursing dated 3/20/24 at 1:34 pm documented the resident left the facility against medical advice at 1pm. The resident signed the AMA paperwork to leave and was provided with his medication. On 4/4/24 at 1:50 pm an interview was conducted with the Interim Director of Nursing (DON). The Interim DON stated on 3/19/24 Resident #2 was observed to inappropriately touch Resident #1's privates and admitted to touching Resident #1s penis when asked. Resident #2 left the facility against medical advice again on 3/20/24 shortly after the police questioned him. The resident signed the AMA paperwork and was provided with his medication. Resident #1's Nurse Practitioner (NP) progress note dated 3/20/24 at 6:03 pm documented a staff member observed Resident #2 touch Resident #1 inappropriately on his private part. Resident #1 had a cognitive deficit, was non-verbal and could not consent to Resident #2 touching him at his private part. Resident #2 was immediately placed on 1:1 supervision in a room by himself. Resident #1 was assessed and there was no evidence of physical harm noted. Resident #1 had a flat affect (facial expression) and was non-verbal. Resident #1 had a head-to-toe assessment, including skin check, and had no evidence of physical harm. The resident's representative and physician was notified. The physician requested Resident #1 be sent out to emergency room for evaluation. On 4/4/24 and 4/5/24 attempts were made to contact Resident #1's representative but were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/4/24 at 1:40 pm an interview was conducted with the Administrator and Director of Nursing (DON). The Administrator stated Resident #1 was inappropriately touched in his genitals by Resident #2 on 3/19/24. The incident was considered abuse and was reported as required. Resident #2 was removed and placed on one-to-one supervision. Resident #1 was assessed for any injury, and none was found. Resident #1 went to hospital and had not returned to this facility; he was transferred to another facility at his responsible party's request. Resident #1 had limited ability to communicate with yes or no by raised hand from direct questions. Resident #1 had impaired cognition and was the victim of sexual assault/touching by Resident #2 who was alert and oriented. Resident #1 was unable to provide a statement. Resident #2 admitted to touching Resident #1's penis. Resident #2 had a sexual offender registry check which was negative. Resident #2 had no prior behavior other than the incident on 3/19/24. The police, resident's representative, and Adult Protective Services were notified. The responding police officer interviewed Resident #2 on 3/20/24 and he admitted to the abuse behavior and left the facility AMA shortly after. Since Resident #1 was not alert and was abused, the police referred the case to the Special Victims Unit (Police Officer #1). The Administrator was notified of immediate jeopardy on 4/5/24 at 1:54 pm. The facility provided the following credible allegation of immediate jeopardy removal with a completion date of 4/10/24: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and While completing routine room rounds, CNA (Certified Nursing Assistant) noted Resident #2 in Resident #1's room. Resident #2 was fondling Resident # 1's penis. Resident #2 was immediately removed from Resident #1's room. Resident #2 was immediately placed on 1:1 supervision. A full head to toe assessment was completed on 3/19/2024 by a licensed nurse on Resident #1 with no issues or areas of concern noted. Resident #1 was sent out to hospital for further evaluation on 3/19/2024 and he was discharged to another facility per family request. Abuse in-service to all staff was immediately initiated by Director of Health Services or designee on 3/19/2024 and Police and Adult Protective Services were notified. Resident #2 discharged Against Medical Advice after spoken to by law enforcement on 3/20/2024. The unit managers on 3/19/2024 completed a full audit on all residents. Unit managers completed head to toe assessments on 26 residents that were most vulnerable for potential abuse with BIMS (Brief Interview for Mental Status) of 9 and below looking for signs and symptoms of abuse or any appearance of fear during their assessment. No areas of concern were noted. Unit managers completed 68 safe survey interviews with the residents with BIMS of 10 and above asking if they had experienced any abuse, including sexual, in this facility. No areas of concern were noted. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/2024, an abuse in-service was initiated per Director of Health Services to ensure that all staff recognize, prevent and protect a resident's right to be free from abuse. This inservice and review of facility abuse policy with all staff initiated a heightened awareness for residents who are most vulnerable and assure that our partners are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of patient abuse. This in-service was completed on 4/9/24, any staff not completing this in-service by this date was removed from the schedule until completed. The Director of Health Services or designee is responsible for ensuring all staff inserviced. Department managers complete on-going routine room rounds. This room round screening form includes questioning alert and oriented residents if they have experienced any abuse or visualizing any signs of abuse from residents unable to respond. On 3/25/2024, the Licensed Nursing Home Administrator and Director of Health Services reviewed and updated facilities preadmission checklist to include Director of Health Services reviewing prior to admission, any potential admission with a history of homelessness, drug addiction and or behaviors. On 3/25/2024 the Admissions Director was notified of updated preadmission checklist. If any applicable items are found, this checklist is sent to the Director of Health Services for admission or denial. The Admissions Coordinator completes a sex offender registry check on all new admissions, anyone appearing on the sex offender registry is denied admission. On 3/25/2024 the Licensed Nursing Home Administrator notified the Director of Health Services to review facility activity report (this is a report within the facilities electronic records) Monday thru Friday, monitoring for, but not limited to behaviors, signs of aggression, wandering, and sexual deviations, etc. This review is discussed during morning clinical meeting, which includes the Director of Health Services, the Assistant Director, the Unit Managers, the Social Worker, and the MDS coordinator. This review is used to update resident care plans and implement medically needed interventions. Direct care staff is trained during orientation of necessary documentation needed, including but not limited to progress notes, point of care documentation, care plan updates, etc. This documented information in turn flows to the facility activity report for review. Date of Immediate Jeopardy removal: 4/10/24 Validation of the credible allegation was completed on 4/9/24: On 4/9/24 at 9:40 AM a tour of the facility was done. During this time there were no residents observed with outward signs of physical abuse. Multiple residents and staff were interviewed during this time. Residents reported they had not been abused or mistreated. Alert residents recalled that facility staff had interviewed them in recent weeks about abuse as per the facility's action plan. Some of the staff reported they had received in-service training per the facility's action plan. These staff members were able to express points covered in the abuse in-service material. Two of the interviewed facility staff, who were working on 4/9/24 reported they had not received abuse training since 3/19/24. A review of in-service training records revealed these two staff members' names did not appear on the facility's in-service sign in sheets for abuse training that had occurred between 3/19/24 and 3/25/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing was interviewed on 4/9/24 at 11:15 AM and reported she had not been the Director of Nursing (DON) at the time of the abuse in-services for staff. An Interim DON had completed the in-service training, and she could not find the list of current employees which the Interim DON had used to ensure all the staff had been in-serviced. The DON stated that she would confirm which employees were current at the facility and compare to the abuse in-service sign in sheets during onsite 4/9/24. During a follow up interview with the DON on 4/9/24 at 3:00 PM, the DON provided an updated list of current employees and reported that she had identified four more employees who had been working since 3/25/24 who had not been in-serviced. On 4/9/24 the DON in-serviced the two staff members identified by the surveyor and the additional four employees she had identified. The DON did this by providing in-person training or calling them on the phone on 4/9/24. This completed the facility's in-service training for all current working employees. During interviews with staff on 3/9/24, staff were interviewed regarding whether they had witnessed abuse. Staff reported they had not witnessed any type of abuse. Staff were knowledgeable regarding what they should do if they did witness abuse. Review of records revealed documentation that Resident #2 was placed on one-on-one supervision from 3/19/24 until his discharge from the facility on 3/20/24. On 4/9/24 the facility presented documentation of audits they had completed per their action plan. The facility also presented an updated preadmission checklist noting that prior to admitting a resident with homelessness, drug addiction, and/or behaviors that the Admissions' Coordinator must consult with the DON per their action plan. There was a signed acknowledgement by the Director of Admissions noting that she understood this new policy. Interview with the DON on 4/9/24 at 3:00 PM revealed that since 3/25/24 there had been no residents requesting admission who were homeless or had drug and/or behavioral problems. On 4/9/24 it was confirmed that Immediate Jeopardy had been removed as of 4/10/24 due to staff education being completed on 4/9/24 prior to the survey's exit.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38129 Based on record review and staff interviews, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification/complaint investigation survey dated 7/13/22 in order to achieve and sustain compliance. This was for a recited deficiency from a complaint investigation survey on 4/9/24. The deficiency was in the area of abuse. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F600: Based on record review and interview of the staff and Police Officer #1, the facility failed to protect a cognitively impaired dependent resident (Resident #1) from sexual abuse by a cognitively intact resident (Resident #2). On 3/19/24 Resident #2 was found in Resident #1's room by Nursing Assistant #1. Resident #2 was observed fondling Resident #1's penis with skin to skin contact from his hand. Resident #1 was unable to stop the sexual abuse due to his limited ability to move and he was non-verbal/unable to call for help. Resident #1 was incapable of consenting to the sexual act and could not express an adverse psychosocial outcome. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause emotional trauma. This deficient practice affected 1 of 3 residents reviewed for abuse. During a previous survey on 7/13/22 the facility failed to protect a resident's right to be free from mistreatment for 1 of 1 resident investigated for staff to resident abuse. The resident sustained a scratch on her face and nose from the altercation with the staff and was crying stating that the altercation made her feel scared and anxious. On 4/18/24 at 9:50 am an interview was conducted with the Administrator. The Administrator stated the abuse deficient practice on 3/19/24 was an unusual circumstance and not the same as the prior abuse deficient practice (7/13/22). The staff addressed the situation as best they could under the circumstances.