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 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Pruitthealth-Carolina Point		STREET ADDRESS, CITY, STATE, ZIP CODE: 5935 Mount Sinai Road Durham, NC 27705	

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(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** 38077 Based on facility video recording, record reviews, and interviews with staff, Nurse Practitioner, Medical Director and the resident's responsible party (RP), the facility failed to protect a cognitively impaired and vulnerable female resident's (Resident #2) right to be free from sexual abuse by a cognitively impaired male resident (Resident #1). On 3/2/25 at 2:50 AM, Nurse Aide (NA) #1 walked past Resident #1 in the hallway. Resident #1 was sitting in his wheelchair with no clothes on and only a towel covering his waist. NA #1 did not intervene and/or redirect the resident. On 3/2/25 at 3:18 AM, Nurse #1 observed Resident #1 on Resident #2's bed. Resident #1 was naked and was kneeling on the bed near the foot board, leaning forward and trying to place his left 2nd and 3rd fingers inside Resident #2's vagina. Resident #2 was lying on her back with a shirt covering her upper body and was not wearing a brief. Resident #2's RP stated Resident #2 must have felt trapped in her bed, may have been scared and was unable to call for help or defend herself. A reasonable person expects to be protected from abuse in their home and would have experienced psychosocial harm with feelings such as fear, humiliation, anxiety, anger and depressed mood. This deficient practice was reviewed for 1 of 3 residents for abuse. Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, viral hepatitis C without hepatic (liver) coma; viral hepatitis B without hepatic coma; Parkinsonism and psychophysiologic insomnia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had unclear speech, had difficulty making self-understood and was assessed as severely cognitively impaired. The assessment indicated the resident did not display any behaviors including wandering behavior during the look back period. Resident #1 required set up/clean up to supervision/touching assistance from staff for his activities of daily living. Resident#1 required set up/clean up assistance for transfer. Resident #1 had no range of motion impairment to his upper or lower extremities and used a wheelchair and walker for mobility. The resident was able to walk 150 feet with set up/clean up assistance from staff. (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	A review of Resident #1's care plan included a focus for behavioral symptoms (start date 9/11/24) with a last revised date 12/17/24. Resident #1 was care planned for socially inappropriate/disruptive behavior related to exhibiting agitation and entering corridor without clothes. Interventions included replacing removed clothing, moving resident to a quiet calm environment and attempting to provide comfort measures for basic needs such as pain, hunger, and toileting when resident becomes socially inappropriate or disruptive. Resident #2 was readmitted to the facility on [DATE] with diagnoses that included dementia, paranoid schizophrenia, and bilateral hearing loss. Review of the quarterly MDS assessment dated [DATE] revealed Resident #2 was assessed as having moderate difficulty hearing, unclear speech and had difficulty making herself understood. Resident #2 was assessed as severely cognitively impaired and did not exhibit any behaviors including rejection of care. The assessment indicated Resident #2 had impairment on both her lower extremities related to range of motion and was dependent on staff and/or needed substantial/maximal assistance from staff for most of her activity of daily living. Resident #2 was assessed as always bowel and bladder incontinent. A review of Resident #2's care plan included a focus for behavioral symptoms (start date 6/29/23) with a last update on 12/3/24. The care plan indicated Resident #2 was at risk for impaired dignity related to removing her clothing due to impaired cognition. Interventions included dressing Resident #2 in a shirt from her wardrobe daily after her bath. Keeping the resident's room at a comfortable temperature to discourage resident from removing clothing. Providing for residents' dignity by pulling privacy curtain or closing the door when unclothed and replacing the removed clothing. The facility video recording was reviewed with the Administrator on 3/11/25. Review of the video recording revealed the following: 1) on 3/2/25 at 2:50 AM, Resident #1 was observed with no clothes, except for a towel around his waist, sitting in a wheelchair. Resident #1 was observed near the nursing station (far end of the hallway). Nursing assistant (NA) #1 was observed entering the hallway and walking past the resident. NA #1 was observed walking around the resident without intervening. 2) On 3/2/25 at 3:03 AM Resident #1 was observed entering Resident #2's room. 3) On 3/2/25 at 3:18 AM, Nurse #1 was observed walking from the far end of the hallway, towards Resident #2's room. Nurse #1 was observed stopping and standing at the doorway of Resident #2's room. Nurse #1 appears to be talking to someone inside the room. 4) On 3/2/25 at 3:20 AM, Resident #1 was observed naked, slowly walking towards his wheelchair which was near the doorway. Nurse #1 assisted Resident #1 in his wheelchair and removed the resident from Resident #2' room and into the hallway. Once in the hallway the towel was observed around Resident #1's waist. During a telephone interview on 3/11/ 25 at 10:45 AM, NA #1 indicated he was working on 3/1/25 from 7:00 PM to 7:00 AM, and was assigned to a different hallway. NA #1 further indicated he kept hearing a beeping sound that night and was in the hallway trying to find out which call light was beeping or if it was some other sound. NA #1 explained while he was passing the hallway, he observed Resident #1 with no shirt on and towel around the his waist, sitting in his wheelchair in the hallway. NA #1 stated he was not paying attention to what the resident was doing, or what he was wearing and passed around the resident. NA #1 further stated Resident #1 was not his assigned resident and he did not pay any attention to how the resident was dressed, if he was wearing briefs or pants. NA #1 stated he was made aware later that Resident #1 was observed on a bed with a female resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's electronic health record revealed a nursing progress note, written by Nurse #1 dated 3/2/24 at 6:48 AM. Note indicated Resident#1 was found in another resident's room in a compromised position. Resident #1 was found on a female resident (Resident # 2) naked and his left (L) second and third fingers in her vagina. Resident was removed immediately from female resident and was placed on 1:1 supervision. The note also indicated Resident #1 had reported to Nurse #1 that Resident #2 had called him in. Review of Resident #2's electronic health record revealed a nursing progress note, written by Nurse #1 dated 3/2/25 at 6:17 AM. Note indicated Resident #2 was found with another resident in her room in a compromised position. The note indicated while Nurse #1 was doing her routine checks on 3/2/25 at 3: 22 AM, she found Resident #1 on top of Resident #2. Resident #1 was found naked with no clothes on. Resident #2 had her blouse on and nothing from waist down. Resident #2's incontinence brief was on the floor by the bed. Resident #2 had his left (L) second and third fingers in Resident #2's vagina. Resident #1 was immediately removed from the resident's room. Resident #2 was unable to explain what had happened due to her cognitive. Resident #2 was immediately assessed by Nurse #1 with another nurse. The note indicated Resident #2 did not complain of any pain, no moaning or facial grimacing, no tears, bruising, bleeding or any trauma was noted. Resident #2 placed under one-to-one supervision. Review of a full body assessment dated [DATE] at 4:08 AM by Nurse #1 revealed Resident #2 was assessed due to resident-to-resident sexual abuse. No negative findings were observed. During a telephone interview on 3/11/25 at 9:06 AM, Nurse #1 stated she worked the 7:00 PM - 7:00 AM shift on 3/1/25 and was assigned to the 500 hallway. Nurse #1 stated Resident #2 exhibited behavior at times of removing her brief and throwing it on the ground. Resident #2 was care planned for this behavior. Interventions included frequent nursing checks to ensure the resident was comfortable. Nurse #1 indicated on 3/2/25 during her rounds around 3:00 AM she observed Resident #1 in Resident #2's room. Nurse #1 stated Resident #2's bed was closer to the doorway. Nurse #1 further stated she was at the doorway, when she saw Resident #1 was on top of Resident #2's bed and was trying to place his fingers in Resident #2's vagina. Nurse #1 stated when she asked Resident #1 what he was doing from the doorway, he got off the bed and walked towards her and his wheelchair near the doorway. Nurse #1 indicated she assisted him in his wheelchair. Nurse #1 stated Resident #2 was wearing her blouse (her upper body covered), her legs were partially covered, and the adult brief was on the floor beside her bed. Nurse #indicated she called for immediate assistance. Resident #1 was taken back to his room and assessed by Nurse #2. Resident #2 was assessed by Nurse #1 and Nurse #3. Resident #2 did not exhibit any signs of fear, pain or discomfort. Nurse indicated both residents were placed on 1:1 supervision. Nurse #3 had notified the Administrator, Director of Nursing (DON), on-call physician and law enforcement. Nurse #1 stated Resident #1 had never exhibited behavior like coming out of his room naked or going into other resident's room. Resident #1 would usually sit outside his room in the hallway, near the nursing station and listen to his boombox. He usually went to bed between 11:00 PM and 12 midnight. Nurse #1 stated Resident #1 was offered ice and water in his room by the NA at around 10:00 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow up interview on 3/11/25 at 12:32 PM, Nurse #1 stated Resident #1 was on his knees, kneeling on the bed, near the bottom on the bed (near the foot board). Nurse #1 stated she could see Resident #1 from the side position, he did not have an erection. He was naked and there was a towel at the base of the bed. Resident #2 was lying on her back on the bed and had a shirt covering her upper body. She had no brief on and there was a brief on the floor. Resident #2's right leg was exposed and left leg covered with the bed linen. Resident #1 was naked and he was leaning forward, extending his left hand to have his second and third fingers near Resident #2's vagina. Resident #1's hand was not inside but near the vagina. Nurse #1 stated when she called out Resident #1 picked up his towel. and walked towards the nurse. Resident #1's wheelchair was near the door and he walked and sat in his wheelchair. The resident was removed from the room and was in the hallway. Nurse #1 stated Resident #2 was smiling back at the nurse and saying okay, I am fine. When Resident #1 was asked what he was doing in the resident's room, he indicated he was called by Resident #2 into her room. During a telephone interview on 3/10/25 at 9:22 PM, NA #2 indicated she usually worked 2 to 3 nights a week and worked the 7:00 PM - 7:00 AM shift. She indicated she was working on the night of the incident (3/1/25). NA #2 stated, the nurse assigned to the hallway (Nurse #1) had called her and informed her to call the other nurse from a different hallway. NA #2 stated she had not witnessed the incident, but when she came back with the other nurses, she observed Resident #1 sitting in his wheelchair with a towel over his legs outside Resident #2's room. Resident #2 was lying in her bed, and her brief was on the floor near the bed. NA #2 further stated Resident #2 exhibited behaviors of removing her brief and throwing it on the floor. NA #2 indicated she did 2-hour incontinent checks to ensure the resident was not wet. NA #2 indicated she had checked the resident earlier that night and the resident did not need any incontinence care. NA #2 recalled Resident #2 was one-to-one monitoring and she was monitoring the resident for the rest of the night. Resident #2 slept the rest of the night without any issues. NA #2 stated Resident #1 needed very limited assistance related to his care. Resident #1 was able to walk in his room and would walk to the toilet independently. NA #2 further stated Resident #1 usually kept to himself and would be outside his room at night with a boombox. NA #2 indicated Resident #1 had never gone into any resident's room or had ever been inappropriate with a female resident. NA #2 stated she has never seen Resident #1 naked or inappropriately dressed at night. NA #2 indicated she did not recollect when she last saw the resident on the night of 3/1/25. During a telephone interview on 3/10/25 at 4:32PM, Nurse #2 stated he was working the 7:00 PM - 7:00 AM shift on 3/1/25 and was not assigned to the 500 hallway where the incident occurred. He indicated a Nurse Aide (name unknown) came to inform him at around 3:00 AM that there was an emergency on the 500 Hallway. Nurse #2 stated when he arrived in the hallway, he observed Resident #1 sitting in a wheelchair in the hallway, near Resident #2's room. Resident #1 was almost naked (towel around his waist and lap). The assigned Nurse to the hallway (Nurse #1) reported to him that she had found Resident #1 in Resident #2's bed with his fingers close to female resident's vagina. Nurse #1 appeared in disbelief that Resident #1 was in Resident #2's room. Nurse #2 stated he looked at Resident #2 from the doorway and Resident #2 appeared to be awake, was calm and smiling at staff. Resident #2 did not appear to be in any distress. Nurse #2 stated he took Resident #1 to his room (down the hall) and asked the resident why he was in another resident's room. Resident #1 appeared confused and stated, he was passing by the room and Resident #2 called him in. Nurse #2 stated he had completed a full body assessment, and no concerns were identified. Nurse #2 stated he usually sees Resident #1 sitting in the hallway with his boombox near his room. Nurse #2 indicated he had never seen the resident naked or going into other resident's room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 3/10/25 at 5:44 PM, Nurse #3 stated she worked the 7:00 PM to 7:00 AM shift and was working on 3/1/25. Nurse #3 stated she was not assigned to the hallway, however between 3:00 AM and 3:30 AM, one of the Nurse Aides (name unknown) came to her and reported that Nurse #1 had an emergency on her hall and needed assistance. Nurse #3 stated by the time she arrived in the hallway, Nurse #1 was reporting to Nurse #2. Resident #1 was in the hallway in front of Nurse #1. Nurse #3 indicated she was given report by Nurse #1 that Resident #1 was naked, in a comprising position, leaning forward, and extending his hand to put his fingers inside Resident #2's vagina. Nurse #3 stated Nurse #1 had asked the resident what he was doing, and he came walking towards her and indicated Resident #2 had called him in her room. Nurse #3 stated she notified the DON and received guidance to do a complete head-to-toe assessment for Resident #2 and report it to the on-call provider. Both residents were to be placed on 1:1 supervision. Nurse #3 stated Resident #1 was taken to his room by Nurse #2 and Resident #1 appeared to be confused. During an interview on 3/11/25 at 8:45 AM and a follow-up interview on 3/11/25 at 12:49 AM, Resident #2's responsible party/ emergency contact (RP) stated she was in shock when she was woken up in the middle of night with a phone call from the facility regarding the incident. Resident #2's RP indicated she was made aware of a male resident in Resident #2's bed. Resident #2's RP stated Resident #2 must have felt trapped in her bed, may have been scared, unable to call for help and waiting for all this to be over. Resident #2's RP further stated Resident #2 was not able to defend herself due to her mental and medical issues. Resident #2 must have been scared and upset that she could not defend herself. Initial Allegation Report dated 3/2/25 and completed by the Administrator was reviewed. The report indicated resident abuse occurred on 3/2/25. A male resident was found in bed with a female resident. No injury, no harm, and no change from either resident's baseline mental and /or physical status. Law enforcement was notified on 3/2/25 at 4:11 AM. A statement written by Clinical Competency Coordinator (Nurse) dated 3/3/25 was reviewed. Statement indicated Resident #1 was interviewed by the Nurse and Wound nurse regarding incident that occurred on 3/2/25. Resident #1 admitted that he went down the hall and went into a resident room and had inappropriate physical contact with another resident. Resident #1 described walking to the resident's room removing the resident's diaper (female resident) and inserting two of his fingers inside her vagina. The statement indicated that Resident #1 had stated that he used his right hand and fingers because his doctor recommended that he have sex. During an interview on 3/10/25 at 5:09 PM, the Director of Nursing (DON) stated she was previously the Clinical Competency Coordinator and had written the statement dated 3/3/25. DON indicated she and ADON (previously Wound Nurse) completed body assessments for Resident #1 on 3/2/25. The DON stated Resident #1 reported that a female resident gestured him to her room, and he went into the room. DON stated Resident #1 demonstrated the hand gesture made by the female resident. Resident #1 did not confirm that he had sex with the resident. Resident #1 stated he had used his hand and fingers because the doctor recommended that he have sex . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's electronic health record revealed the Nurse Practitioner (NP) note dated 3/3/25 written by NP #2 indicated per nursing staff report, on 3/2/25 Resident #1 was sent to Emergency Department (ED) for psychiatric evaluation after the resident was discovered in another resident's room exhibiting inappropriate sexual behavior. The note indicated Resident #1 was alert, sitting in his wheelchair during the assessment and was at his baseline. It was noted nursing staff had implemented frequent rounding and closer monitoring of resident. The Psychiatric NP was made aware. The NP documented that per the Psychiatric NP recommendation medication was adjusted and new order were implemented to increase lithium to 450 milligrams (mg) by mouth two times a day, increase lorazepam from 1 to 2 mg by mouth two times a day and increase trazodone from 50 to 100 (mg) at night. During an interview on 3/10/25 at 1:45 PM, Nurse Practitioner (NP) #2 indicated she was notified by the on-call NP about the incident. Resident #2 had diagnosis of schizophrenia. Resident #1 was sent to the hospital for a psychological evaluation as this was the first time Resident #1 had exhibited any sexual behavior. NP #2 indicated Resident #1 returned to the facility without any new orders from the hospital. NP #2 stated during her assessment Resident #1 was at his baseline and anxious. NP #2 indicated she notified the psychiatric NP about Resident #1's episode of inappropriate sexual behavior with a female resident. Per Psychiatric NP recommendations the resident's medications were increased. Lithium was increased from 300 - 450 mg and trazodone was increased from 50 to 100 mg. Resident #1 was followed by the Psychiatric NP. Review of Resident #1's electronic health record revealed a Psychiatry progress note dated 3/6/25 written by Psychiatric NP #3. Note indicated Resident #1 was seen for a psychiatric medication follow up visit. Resident #1 had diagnoses of schizoaffective disorder, bipolar disorder and insomnia. Schizoaffective disorder was managed with a combination of medications. The note indicated lithium levels were found to be subtherapeutic, necessitating an increase in dosage from 300 mg to 450 mg. Resident #1 was calm and stable with no aggression or significant paranoia observed during assessment. During a telephone interview on 3/11/25 at 10:50 AM, Psychiatric NP #3 stated he was notified by the medical team to assess Resident #1 and Resident #2 due to inappropriate sexual behavior and abuse incident that occurred in the facility. After the incident Resident #1 was sent to the hospital for psychiatric evaluation and returned to the facility with no change in medication from hospital. NP #3 indicated at the time of assessment, when Resident #1 was asked about the incident, he did not make any sense. The resident was confused and upset about having 1:1 supervision. NP #3 stated the resident was educated on the reason for supervision. Psychiatric NP #3 stated he had made some changes for residents' medication to help the resident to calm down. NP indicated Resident #1 had not exhibited such inappropriate behavior prior to this incident. Review of Resident #2's electronic health record revealed a Nursing progress note dated 3/3/25 that indicated Resident #2 was assessed by the provider. Psychiatric services were notified with no med changes. Resident #2 denied any pain and/or discomfort and was not in any acute distress. Note indicated that the resident's blood was drawn for serum blood STD (sexually transmitted disease) panel testing. Review of Resident #2's electronic health record revealed a progress note written by NP #1 dated 3/3/25. Note indicated Resident #2 was seen for a sexual assault incident. Resident #2 unable to answer questions secondary to dementia. Resident denied any vaginal pain or any pain at the time of assessment. Resident#2 was pleasantly confused, and her mood was stable. Resident #2 had no recollection of the assault and had no acute complaints. The STD panel order pending. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/10/25 at 1:03 PM, Nurse Practitioner (NP) #1 stated she was made aware that a male resident had placed fingers in Resident #2's vagina. NP #1 indicated that during the physical examination Resident #2 appeared to be confused and was at her baseline. The physical examination of Resident #2 included thorough examination of the vaginal and peri areas and found no indication that any sexual contact had occurred. Resident #2 did not report any pain. Skin checks around the vagina revealed no scratches, or redness. NP #1 stated she did speak with Resident #2's family and they did not want the resident to be sent out to the hospital. Lab work regarding STD was ordered for the resident. Review of Resident #2's electronic health record revealed a psychiatric progress note written by Psychiatric NP #3 dated 3/6/25. The note indicated Resident #2 was seen for an acute psychiatric medication visit. Resident #2 had diagnoses of paranoid schizophrenia, depression, insomnia and dementia. During the assessment resident was stable, no hallucinations, no changes in mood and behavior. Resident #2 was unable to answer any questions appropriately due to cognitive impairment. NP #3 documented that staff should notify the provider of any change in mood and behavior. No medication changes were made. During a telephone interview on 3/11/25 at 10:50 AM, Psychiatric NP #3 stated he was notified about the sexual abuse incident that occurred in the facility. NP #3 stated usually during his visits, Resident #2 was not very alert and did not respond well. However, during the assessment on 3/6/25 Resident #2 was awake, seemed happy and smiling at the NP. NP #3 stated the resident was unable to provide details of the incident due to her cognitive impairment. Resident #2 was at her baseline and no change in mood or behavior was observed. He indicated no medication changes were made. Investigation Report dated 3/7/25 and completed by the Administrator was reviewed. The report indicated resident abuse occurred on 3/2/25, and the facility was notified on 3/2/25 at 3:38 AM. Report further indicated a male resident was found in bed with female resident. No injuries and/or change in baseline physically or mentally noted. Nursing staff did not notice any change in behavior. No mental anguish and physical injury/harm noted. Family reports no change in baseline at all daily since event. The incident occurred between Resident #1 and Resident #2 and was witnessed by Nurse #1. Resident #1 was sent to the hospital for psychiatric evaluation and was placed on 1:1 supervision until discharged from facility. Resident #2 responsible party refused twice to send the resident out to the hospital for evaluation. Resident #2 was evaluated by an in-house provider. Investigation completed on 3/7/25 by previous interim Director of Nursing (DON). The Allegation was substantiated. Nurse #1 and Nurse Aide (NA) 1 were terminated for failure to intervene and perform job duties that could have negated this event from occurring. Law enforcement and Adult protective services were notified on 3/2/25. During an interview on 3/10/25 at 3:35 PM, the Social Worker (SW) indicated she received a call from the Administrator on 3/2/25 at around 4:15 AM, that a male resident was in bed with a female resident. The SW indicated she completed the Brief Interview for Mental Status (BIMS) for all residents on 3/2/25. All residents who were alert and orientated with a Brief Interview for Mental Status Score (BIMS) of 10 and above completed an abuse questionnaire. The SW further indicated questionnaire included how they felt about their safety, care needs and who they need to contact at the facility with concerns. The audit was completed on 3/2/25 and there were no negative findings. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 3/10/24 at 3:15 PM, the previous interim Director of Nursing (DON) stated she was notified on 3/2/25 at around 3:20 AM to 3:30 AM. The interim DON indicated a nurse reported that a male resident was with a female resident in her room. The interim DON indicated that initially the nurse had reported that Resident #1 had his 2 fingers inside Resident #1's private parts (vagina) and later Nurse #1 explained the incident and indicated the resident's fingers were near Resident #2's vagina. Interim DON indicated both residents were placed on 1:1 supervision for the rest of the night. The Administrator was notified of sexual abuse. The interim DON stated during the investigation; the video camera recordings were reviewed. Nurse #1 was sitting near the nurses' station possibly on her phone (head down). Resident #1's room was near the nursing station and Nurse #1 failed to see Resident #1 go out of his room into the hallway almost naked and failed to prevent this incident. Nurse #1 was terminated. Review of Resident #2's electronic health record revealed a progress note written by the Administrator dated 3/3/25. The note indicated Resident #2's responsible party (RP)/ emergency contact was notified about the sexual assault. The Administrator and the interim Director of Nursing (DON) discussed the incident with Resident #2's RP and informed the RP of the NP assessment, referral to Psychiatric NP, plan of care and other nursing care. The RP was provided options to send the resident to emergency room (ER) for SANE (sexual assault Nurse Examiner) exam and STD (sexual transmitted disease) testing. Resident #2's RP declined ER visit and indicated being content with NP evaluation and for STD panel to be drawn. During an interview on 3/11/25 at 8:30 AM, the Administrator stated he was notified by the previous interim DON on 3/2/25 at around 3:30 AM about the sexual abuse incident. DON reported that Nurse #1 had observed Resident #1 in Resident #2's room. Resident #1 was naked, and on Resident #2's bed. Both residents were placed on one-to-one supervision. Administrator further indicated during the investigation, the hallway video cameras were reviewed. Resident #1 was observed naked with a towel around his waist coming out of his room in his wheelchair. Resident #1's room was just opposite the nursing station. NA #1 was observed on camera, not intervening with Resident #1 in the hallway. NA #1 was observed to walk around the resident without addressing the resident. Nurse #1 was observed to be at the nursing station, sitting in a chair and unclear if she was sleeping or on phone. Nurse #1 was not overseeing the NAs assigned to her. Administrator indicated had NA #1 intervened or Nurse #1 seen Resident #1 t coming out of the room and had performed her duties, this could be avoided. Hence both staff were terminated. Administrator stated the Plan of correction was immediately implemented. Administrator indicated Resident #1 was sent to the hospital for psychiatric revaluation and returned to the facility on [DATE] later that night with no medication change. Resident #1 was assessed by the facility NP and Psychiatric NP and medication adjustment were made. Resident #1 was placed on 1:1 supervision until discharged from the facility on 3/6/25. The Administrator further stated he spoke with Resident #2's RP on 2 different occasions and the resident's family declined Resident #2 to be sent to the hospital. Resident #2 was assessed by the NP and Psychiatric NP and no medication changes were made. Resident #2 was assessed to be at her baseline. Resident #2's family had visited the resident on multiple occasions and they did not report any change in Resident #2's behavior or moods. All residents whose Brief Interview for Mental Status Score (BIMS) of 10 and above, completed the abuse questionnaire. Residents reported feeling safe and no concerns were reported to the Social Worker. All residents with a BIMS less than 10, a full body audit was completed by the Wound nurse and Clinical competency Coordinator who were Registered Nurses (RN) and no issues were reported. Abuse /Neglect, sexual abuse and reporting educational in-service were initiated for all staff by Clinical Competency Coordinator on 3/2/24. (continued on next page)

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 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Carolina Point	5935 Mount Sinai Road Durham, NC 27705

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(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	During a telephone interview on 3/11/25 at 11:28 AM, the Medical Director indicated he was aware of the sexual abuse incident the following morning. Medical Director stated the Nurse Practitioner had assessed Resident #2 and reported no injuries, bleeding or any bruising. Resident #2 did not exhibit any change in behavior and was at her baseline. Blood work was drawn and Resident #2's lab reports showed no negative findings. The Medical Director stated Resident #1 was sent to the hospital for psychiatric evaluation the following morning and returned later with no change in medication. Resident #1 had previously not shown any sexual inappropriate behavior. Resident #1 was assessed by NP #2 and no issues were reported. Medical Director indicated Resident #1, and Resident #2 were followed by the Psychiatric services. After psychiatric assessment Resident #1 had some medication changes made by Psychiatric services. Resident #2 had no changes made to her psychiatric medications. Resident #1 was discharged home with home health services per family request. The Administrator was notified of immediate jeopardy on 3/11/24 at 4:05 pm. The facility provided the following Corrective Action Plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 3/2/25, Nurse #1 entered Resident #2's room. Resident #1 was observed in bed with Resident #2. Resident # 2's brief was observed to be on the floor. Resident #2 was dressed in a top and bed covers were pulled up according to the s interview with Nurse #1. Resident #1 had his left hand near resident # 2's vagina. Nurse #1 immediately told Resident #1 to stop, and then Resident #1 walked towards Nurse #1 and sat back in his Wheelchair. Nurse #1 called for assistance from other staff members. Resident #1 was returned to his room immediately by Nurse #2, and a complete head-to-toe skin observation was completed on Resident #1 with no noted bruising, bleeding, pain, or concerns. This was done to ensure there was no skin impairment because of the incident. Resident #1 was immediately placed on 1:1 observation with a staff member. Resident #2 was assessed by Nurse #1 and another nurse to include complete head-to-toe observation and external genital observation with no redness, pain, swelling, bruising, or bleeding noted. Resident #2 was observed in a pleasant mood as evidenced by staff reporting that she was laughing, waving at them and gesturing at them. She