

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  02/11/2026
NAME OF PROVIDER OR SUPPLIER  Pruithhealth-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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, and staff interviews, the facility failed to provide nail care for Resident #137 who required staff assistance for personal hygiene. This deficient practice affected 1 of 8 dependent residents reviewed for activities of daily living (Resident #137). The findings included: Resident #137 was admitted to the facility on [DATE] with diagnoses of recent partial amputation of right little finger and right ring finger on 1/18/26, end stage renal disease, Type 2 diabetes mellitus, and cerebrovascular accident. The admission Minimum Data Set (MDS) dated [DATE] showed Resident #137 was cognitively intact. He required substantial assistance for toileting hygiene and set up/clean up assistance with personal hygiene. Resident #137's care plan dated 2/6/26 had a focus for Activities of Daily Living self-care deficit with interventions that included check nails and ensure they are clean and have neat appearance and provide showers per schedule. During an observation and interview with Resident #137 on 2/8/26 at 3:00 PM, all nails on his left hand were observed to have smooth edges and extended approximately a quarter inch beyond the fingertips with thick black matter under each nail. Resident #137 stated he had not asked staff to trim or clean his nails but stated he did not like them long and dirty and wished the staff would cut them and clean them. During an observation of Resident #137 on 2/9/26 at 9:17 AM, all nails on his left hand were observed to have smooth edges and extended approximately a quarter inch beyond the fingertips with thick black matter under each nail. During an observation of Resident #137 on 2/10/26 at 9:34 AM, all nails on his left hand were observed to have smooth edges and extended approximately a quarter inch beyond the fingertips with thick black matter under each nail. A review of the bath/shower schedule revealed Resident #137 was scheduled for a bath on Thursdays and Saturdays on the 7:00 PM to 7:00 AM shift. There were no shower and personal hygiene sheets for Resident #137 for November 2025 through February 2026. An interview was conducted on 2/10/26 at 5:59 AM with Nurse Aide (NA) #7 and NA #9 who worked night shift (7:00 PM to 7:00 AM) and were assigned to Resident #137 on the scheduled shower/bath day. Nurse Aide #7 stated each resident was assigned a bath day and this was posted on the unit shower schedule. When the bath was completed the nurse aide would initial the Bath Check List if fingernails were cut or needed to be cut/trimmed, the resident refused bath care, or if anything was not able to be completed. Nurse Aide #7 stated she would notify the nurse if nails needed to be done because a resident might have diabetes and nail care would need to be completed by the nurse. Nurse Aide #7 and NA #9 both stated they did not notice the condition of Resident #137's fingernails. An interview was conducted on 2/11/26 at 1:00 PM with NA #4 who stated she had completed a bed bath for Resident #137 earlier that day. She stated she had not observed any personal care issues that should be reported to the nurse. She stated she did not recall his nails being long or dirty. An interview was conducted on 2/10/26 at 6:12 AM with Nurse #12 who was assigned to Resident #137. She was unaware of Resident #137's need for nail care. Nurse #12 stated no nurse aide had reported he required nail care and she did not observe</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  345551	Facility ID:  345551  If continuation sheet Page 1 of 5

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the condition of his nails. She stated as Resident #137 had diabetes the nurse aide could provide hand washing assistance but not nail trimming. Nurse #12 did not know if he could clean his own nails and trim them if provided set up. An interview was conducted on 2/9/26 at 2:00 PM with the Unit Manager (Nurse #11) who stated when a resident was scheduled for a bath/shower it was expected that nail care, hair care, and shaving would be done. She stated the NA would let the nurse know if a resident needed nail care so the nurse could check if the resident had diabetes in which case the nurse would be responsible for providing nail care. Nurse #11 stated she had not looked at Resident #137's nails and was unaware if he was dependent on staff for nail care. She did not know why there were no shower/bath sheets for Resident #137. On 2/11/26, at 3:12 PM, an interview was conducted with the Director of Nursing (DON), who stated that when a resident was scheduled for a bath, the service included shaving, hair care, and nail care. She stated after completion of the bath or shower the nurse aide would complete the skin care sheet that stated, by signing this I agree that that shaving, hair, and nail care has been done. She further stated if the nurse aide noted long or dirty nails this would be reported to the nurse who would check if the resident had diabetes. If a resident had diabetes, the nurse would be responsible for cutting and cleaning of the nails. The DON indicated it was the Unit Manager's responsibility to complete a weekly audit to validate findings on the bath sheets. She stated clean and neat nails were an expectation and she did not know why no bath sheets were completed for Resident #137. The Administrator was interviewed on 2/22/26 at 5:32 PM. He stated it was unacceptable for residents to have dirty fingernails. He stated it was the responsibility of the Nursing Department to provide personal care, and the nursing staff should ensure residents have neat and clean nails.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews, and resident and staff interviews, the facility failed to provide podiatry services to 1 of 1 residents with diabetes who were reviewed for foot care (Resident #104). Findings included: Resident #104 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes with neuropathy, other circulatory complications, hemiplegia (loss of the use of the affected side of the body, and hemiparesis (weakness of the affected side of the body) following a nontraumatic subarachnoid hemorrhage (bleeding into the brain) affecting the left non-dominant side. The care plan dated 12/12/25 indicated impaired physical mobility and deconditioning related to recent hospitalization for hemiplegia, and a decline in activities of daily living related to stroke. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #104 had moderately impaired cognition and required substantial to maximum assistance with activities of daily living. Nurse's progress notes from 12/1/25 to 2/9/26 did not indicate any notes regarding Resident #104's long toenails or an appointment for the podiatrist. A review of the shower book over the past three months (December 2025 to present) did not indicate that Resident #104 had her toenails trimmed or that they needed trimming. A review of the nurses' weekly skin assessments, (December 2025 to present), did not indicate that Resident #104 needed her toenails cut. The skin assessment sheets that are attached to the shower sheets were not checked for Resident #104 needing a nail trim. A review of the podiatry lists for the past six months (July 2025 and December 2025) did not indicate that the resident had been placed on any of them by the social worker. The Podiatrist next visit would be 2/12/26. An interview and observation with Resident #104 were done on 2/8/26 at 3:10 PM. The resident called out, Hey, can you help me? and indicated that her toes hurt. When observing Resident #104's toenails, it was noted that she was not wearing socks; her great toenails were long, thick, and jagged. The remaining toenails were also thick, long, and jagged. An interview with Nurse Aide (NA)4 on 2/9/26 at 11:38 AM indicated that she could not cut Resident #104's toenails; the nurse needed to do that. When asked how the nurse was informed when the toenails needed to be cut, she said the nurse aide told them, or sometimes the residents told the nurse themselves. Nurse Aide #4 was asked whether she had told the nurse that Resident #104's toenails needed to be cut during that day's care; she said no. Nurse Aide #4 indicated that Resident #104 had diabetes, and the nurse should have noticed that her toenails needed cutting during the skin assessment. An interview with the Charge Nurse on 2/9/26 at 2:48 PM indicated that she had not cut Resident #104's toenails, and the resident had not asked for her toenails to be cut. An interview on 2/10/26 at 11:25 AM with the social worker indicated that Resident #104 had not been identified as needing to see the podiatrist. It was further indicated that when the nurse conducts the skin assessment and determines that the resident needs to be seen by the Podiatrist, the nurse will inform the social worker that the resident needs to be added to the podiatrist's list. The podiatrist's list is sent when he informs the facility he will be coming on a specific date. An interview on 2/10/26 at 11:40 AM with Nurse Aide #5 regarding the policy for cutting toenails indicated that the aide was to tell the nurse if the resident needed their toenails cut. If the resident could not tell the nurse, or if the resident had diabetes, the resident had to be seen by the foot doctor. An observation and interview on 2/10/26 at 1:00 PM revealed that Resident #104's toenails had not been cut. She was asked if she would like to go to the foot doctor to have them cut, and she said yes. An interview on 2/10/26 at 10:18 AM with the Director of Nursing (DON) indicated that the residents with diabetes had their nails cut by podiatry. She then said she was not familiar with the resident and would make sure she was put on the podiatry list. She further stated that the nurses should have been assessing the residents' feet and either cutting them or having them</p> <p>(continued on next page)</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>placed on the podiatry list. An interview on 2/10/26 at 2:30 PM with the Administrator indicated that he was not sure why Resident #104 had not been on the podiatrist list and was unaware that she had needed to be seen by podiatry. The Administrator further stated that he would ensure Resident #104 was added to the list. The Administrator further indicated that he expected residents' toenails to be trimmed and that, if any issues arose, podiatry would be consulted. He further indicated that the nurses were responsible for ensuring the social worker received a current list of residents who needed to see the podiatrist, and that the social worker would ensure all residents were added to the next visit.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>F812 -EBased on observations and staff interviews, the facility failed to label, date, seal and/or remove expired food items stored for use in 1 of 1 walk-in cooler, the dry goods storage room, and 1 of 1 of 1 walk-in freezer and failed to ensure food service equipment was clean. These practices had the potential to affect food being served to residents. The findings included:a. An initial tour was conducted with the Dietary Manager on 2/8/26 at 10:17 AM. Observations made at the time of the initial tour identified the following concerns in the walk-in cooler:- Two crates of chocolate milk cartons (48) with the expiration date 2/7/26 remained in the refrigerator to be served. One 5-pound plastic bag of partially used shredded cheddar cheese was observed left open to air (not sealed). The bag was dated as opened on 2/5/26. An interview with the Dietary Manager on 2/8/26 at 10:17 AM during the tour indicated that she was new to the position and was working to get the staff on track by ensuring dates were checked each morning before serving breakfast and removing expired items before any food preparation. b. An observation made on 2/8/26 at the time of the initial tour (10:17 AM) identified the following concern in the dry food storage room: - An undated bag of rice, in a plastic bag left open to air.An interview with the Dietary Manager on 2/8/26 during the initial tour indicated that she had told the dietary staff to make sure all dry goods were tied up or sealed and dated with an open date to prevent contamination and keep bugs out.c. Additional observations were made during the initial tour with the Dietary Manager on 2/8/26 of the walk-in freezer, which identified the following concerns:- An open cardboard box containing 10 pounds of frozen chicken breast patties dated 2/7/26. The plastic bag inside the box was observed to be open to air (not sealed). The chicken breast patties appeared to have light edges, which may indicate freezer burn.- Three 5-pound rolls of frozen ground beef were placed on the wire rack and not dated.An interview with the Dietary Manager during the initial tour on 2/8/26 reported food items placed in the freezer should be dated by the date they were placed in the freezer and sealed. She further stated she would make sure ground beef was placed on a tray and dated when being frozen. d. Observations made during the initial tour with the Dietary Manager on 2/8/26 at 10:30 AM identified concerns with the cleanliness of equipment used within the Dietary Department. These included:- The free-standing rack for cutting boards was observed to have a dark brown buildup of debris between the sections where the cutting boards were placed. Some of the cutting boards were noted to be touching the dark brown debris. One side of the stove/oven was observed to have a dark brown, sticky grease buildup.- The bottom edge of the free-standing refrigerator had thick dust and debris built up at the bottom edges of the door.- The utility cart that held condiments and silverware was visibly soiled with dried debris, and crumbs were in between the individual compartments and outside edges.An interview with the Dietary Manager (DM) during the initial tour on 2/8/26 revealed that staff had not been checking to ensure each station was cleaned due to a lack of guidance after the previous dietary manager left suddenly. The DM further indicated that areas such as prep tables, coffee/condiment carts, and equipment needed more attention when cleaned by staff after use. An interview was conducted on 2/11/26 at 4:55 PM with the facility's Regional Director of Dietary Services. At that time, the findings of the Dietary Department's initial and follow-up tours were shared. Upon inquiry, the Regional Director reported that she would expect all food containers to be sealed and properly dated with open and expiration dates, and the Dietary Department should be cleaned, and any concerns identified during the observations should have been cleaned in accordance with the cleaning schedule and/or caught by the daily rounds of the department.</p>		