	-	ID HUMAN SERVICES				FOF	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION			E SURVEY IPLETED
		345566	B. WING			0	C 7/01/2024
NAME OF PI	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS,	CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHV MONROE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00			
F 600	conducted 6/25/2024 facility's credible alleg removal was validate exit date was change intake was investigate 1 allegation resulted in NC00282402 resulted Immediate Jeopardy CFR 483.12 at tag F6 of J. CFR 483.12 at tag F6 of J. The tags F600 and F6 Quality of Care. Immediate Jeopardy was removed on 6/29 survey was conducte Free from Abuse and	500 at a scope and severity 507 at a scope and severity 607 constituted Substandard began on 6/16/2024 and 0/2024. A partial extended d.	F 60	00			7/19/24
SS=J	§483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit	involuntary seclusion and ical restraint not required to edical symptoms.					
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						07/19/2024

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.

		MEDICAID SERVICES				1	O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· /	E SURVEY IPLETED
			A. BUILDI	NG			
		0.45500					С
		345566	B. WING			07/01/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTH	EALTH-UNION POINTE				510 WEST HIGHWAY 74		
				м	ONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page		F	600			
	physical abuse, corpo						
	involuntary seclusion;						
		is not met as evidenced					
	by:	iew, observations, and staff			Nurse Aide #1 and Nurse Aide #2		
		er interviews the facility failed			assisted Resident #1 off Resident #2.		
		1's and Resident #2's right to			Resident#1 was dressed and wheeled	to	
		buse. On 6/16/24 staff			her room. Resident #1 was also placed		
		e Aide #2, and Nurse #1)			1:1 monitoring. Resident #1 s skin	1011	
		1 (female) in Resident #2's			assessment was completed on 6/19/20	124	
		nt #2 was lying on his back			There were no findings. Resident #2		
	on the bed naked from				skin assessment was completed on	5	
		op of him with her brief and			6/26/2024.There were no findings.		
		kles. Resident #2 had one			Resident #1 has remained on 1:1 since	<u>_</u>	
		his and was "trying to insert			the incident date. Resident #1 and	-	
		t #1, and he was touching			Resident #2 were evaluated by their		
	her "private parts" wit	-			psychiatrist on 6/20/24. Resident #1 s		
		nutes after the residents			medications paroxetine, a		
	were separated, Nurs				psychotherapeutic medication, was		
	•	Resident #2's room with her			evaluated and increased. No changes		
	hands on the front of				were made to resident #2 s medicatio	n	
		e them". Resident #1 and			regimen. Resident #1 s care plan and		
		ere cognitive impairment and			resident profile and was revised on		
	did not have the capa	•			6/27/24 to reflect the medication change	les	
		pects to be protected from			and 1:1 monitoring. Resident #2 s car		
		environment and sexual			plan was revised on 6/27/24 to include		
	abuse would cause tr				sexually inappropriate behavior toward		
	deficient practice affe	cted 2 of 4 residents			others. Resident #1 will remain on 1:1		
	reviewed for abuse.				monitoring until further evaluated and		
					released by the facility psychiatrist.		
	Immediate Jeopardy	began on 6/16/2024 when					
	the facility failed to pr	otect Resident #1's and			All other residents have the potential to	be	
		be free from sexual abuse.			affected by the deficient practice.		
		was removed on 6/29/2024					
	when the facility impl	lemented an acceptable			To identify other residents having the		
	credible allegation of				potential to be affected by the same		
		remains out of compliance			deficient practice, the facility completed	ł	
	at a lower scope and	a a vanite da val af "D" (na			interviews with all alert and oriented		
		or more than minimal harm			Interviews with an alert and onented		

Facility ID: 080171

If continuation sheet Page 2 of 28

STATEMENT OF I AND PLAN OF CC NAME OF PROV PRUITTHEAL (X4) ID PREFIX TAG F 600 C th en p F F 8 3. W	DEFICIENCIES ORRECTION WIDER OR SUPPLIER	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345566	` '		CONSTRUCTION	(X3) DATE	
PRUITTHEAU (X4) ID PREFIX TAG F 6000 C th eu p F 600 C th eu p C th eu p C th eu p th eu p th eu p th eu				(X2) MULTIPLE CONSTRUCTION A. BUILDING			LETED
PRUITTHEAU (X4) ID PREFIX TAG F 6000 C th eu p F 600 C th eu p C th eu p C th eu p th eu p th eu p th eu			B. WING				C 101/2024
(X4) ID PREFIX TAG F 600 C th e p F F R 3. W				STF	REET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG F 600 C th e p F F R 3. W				351	10 WEST HIGHWAY 74		
F 600 C th F 600 F F R 3. W	LIH-UNION POINTE			MC	DNROE, NC 28110		
tr ev p F R 3. v	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
tr ev p F R 3. v	Continued From nors	. 0					
e p F 3. w	Continued From page		F 6	500			
p F 3. w	hat is not immediate				higher to inquire if they had ever been		
F R 3, w	-	ed and monitoring systems			physically, verbally, sexually, mentally		
R 3. W	out into place are effe	CUVE.			abused or exploited, to determine if at point facility staff had not met their ne	•	
R 3/ w	-indings included:				and if they had ever witnessed abuse		
3. w	indinge inoldede.				neglect $(6/28/2024)$ . For those reside		
3. w	Resident #1 was adm	itted to the facility on			determined to not be cognitively intact		
		agnoses included dementia			and/or with a BIMs score of lower that		
	vith psychosis and a	cognitive communication			body audits were completed to identify	у	
d	leficit.				any signs of abuse or neglect, and to		
					determine if residents had any injuries		
		Data Set assessment dated			unknown origin (6/28/2024). Any adve	erse	
		esident #1 was severely			findings were reported to the	the e	
		ind required moderate ers, used a wheelchair for			Administrator, and became subject to facility s Policies, Procedures, and	lne	
		and had not had behaviors.			Protocols for Abuse. One bruise noted	4	
	nobility in the facility,				investigation completed, and findings		
R	Resident #1's care pla	an was reviewed and a care			to all regulatory agencies as required.		
		ed 2/10/2024 and updated					
0	on 6/11/2024 indicate	d Resdient #1 required			To ensure that the deficient practice w	/ill	
	•	sistance with activities of			not recur, an Ad Hoc Quality Assurance		
		be allowed to attempt			and Performance Improvement was h		
		g before being assisted and			(6/26/2024). Attendees Meeting atten	dees	
	•	care as needed and during			included the Administrator, Clinical		
		blan problem dated 8/1/2023			Competency, Director of Health Service Social Worker, Environmental Service		
		had physical and verbal ng to touch others (residents			Dietary Manager, Case Mix Director,		
		but, resisting care, and not			Mix Coordinator, Financial Counselor,		
		d during behaviors. The			Nurse Navigator, and Admissions		
	• •	licated staff would assess			Director, on the facility s Prevention	of	
		endangers the resident or			Abuse, Neglect, Exploitation,		
0	others and intervene	if necessary.			Mistreatment, and Misappropriation P	olicy	
					and Procedures. This review also		
		itted to the facility on			included education to reiterate that se		
		gnoses included a history of			abuse is non-consensual sexual conta	act	
S	stroke and schizophre	enia.			of any type.		
		esmont dated 6/5/2024			Additionally, in the event of a resident-to-resident nonconsensual		
		essment dated 6/5/2024 as severely cognitively			sexual behavior, or an observed sexu	al	

Facility ID: 080171

TATE AFAIT					0.00		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>		0	
		345566	B WING		C		
		545566				07/01/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74			
				MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	e 3	F 60	00			
	impaired; was indepe			act without the staff⊡s prio	or knowledge of		
		; and he had not behaviors.		consent of both residents	-		
		,		of 10 or greater with cogni			
	Resident #2's care pl	an was reviewed and a care		consent to the sexual act,			
	plan for 1/6/2024 stat	ed he was independent with		will be separated, the staf	f members will		
		d toileting and had verbal		report the behavior to the			
		ng others, screaming at and		who reports to the Nurse	•		
		pisodes of fighting others.		Administrator. The resider			
		Resident #2's care plan		provided with a one-to-one			
	maintain a calm envir	avoid overstimulation and		until a review is made by t	•		
	maintain a caim envir	onment.		(Nurse Practitioner, Physic Psychiatrist) to determine			
	Review of Resident #	1's medical record revealed		for the one to one. The Ad	-		
		lote written by the Director of		and/or Clinical Competence			
		S) on 6/16/2024 at 5:30 pm		Educated began educating	-		
	•	nt #1 exhibited behaviors.		facility Prevention of Abus	-		
				Exploitation, Mistreatment	-		
	A Nurse's Progress N	lote written by the DHS on		Misappropriation Policy ar	nd Procedures.		
		in Resident #2's electronic		Facility Staff who are sche			
		24 at 5:35 pm indicated		receive in-person education	-		
	Resident #2 exhibited	d behaviors.		Competency Coordinator,			
	• • • • • • • • • • • • • • • • • • •			Department Manager, or A			
		written on 6/16/2024 at 1:30		Staff not scheduled to wor			
		revealed the following: She		verbal education over the			
		s room and found Resident with his body perpendicular		Clinical Competency Coor respective Department Ma			
		anging over the side of		Administrator. This educat			
		t #1 was lying on top of		been added to the genera			
		sidents were naked from the		newly hired staff and revie			
		dent #2 had one hand on his		Clinical Competency Coor	•		
	penis and was trying	to put his penis in Resident					
		ing her private parts with his		Systemically, in addition to	o the facility⊡s		
		ide #2 called out to Nurse		general orientation discus			
		de #1 called out to Nurse		and neglect, an annual rev			
		arrived at the room they		facility Prevention of Abus	-		
		off Resident #2, dressed		Exploitation, Mistreatment			
	her, and removed her	r from the room.		Misappropriation Policy ar			
	Nurse Aide #2 was in			will be conducted (6/28/20	124). I NIS		

Facility ID: 080171

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		MEDICAID SERVICES				MB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	`	(3) DATE SURVEY COMPLETED
	oonneonon		A. BUILDING			
			D 14/010			С
		345566	B. WING			07/01/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS	, CITY, STATE, ZIP CODE	
	ALTH-UNION POINTE			3510 WEST HIGH	WAY 74	
				MONROE, NC 2	28110	
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACI	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIC
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS	-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 600	Continued From page	e 4	F 60			
	10:00 am by phone a	nd she stated she worked		reviewed du	uring general orientation for	
	on 6/16/2024 and fou	nd Resident #1 in Resident d Resident #2 was lying on			staff and reviewed.	
		vith his legs perpendicular to			the performance of this	
		nanging over the side of the			nange, interviews will be	
	÷	lying on top of him. Nurse		-	for residents with a BIM score	
		ent #2 had an erection and			ove and skin checks will be	
		nis penis and was trying to			for residents with BIMS score	
		1's vagina but was not			w. These audits will be	
si do ha ca		ed she was just inside the		-	for ten residents weekly for	
		when she saw what was			. Thereafter these audits will b	e
	-	out to Nurse Aide #1 who		conducted	for eight residents monthly for	
		urse Aide #2 stated they did			ns. Thereafter these audits wil	
		t #1 and Resident #2 before		be conduct	ed for eight residents quarterly	y I
	-	#1. She indicated then			ewed and revised by the	
	-	out to Nurse #1 to come to			urance Performance	
	the room. Nurse Aide	e #2 stated Nurse Aide #1			nt Committee.	
	left the room to get N	urse #1 and it was only a				
	few minutes before N	urse #1 came to the room.		The Directo	or of Health Services will repor	t
	She indicated she rer	nained standing inside the		the analysis	s of the resident interviews an	d
	doorway to the room	until Nurse #1 got to the		skin observ	ations to the facility Quality	
	room. Nurse Aide #2	stated she did not think		Assurance	and Performance	
	about seperating Res	ident #1 and Resident #2		Improveme	nt Committee monthly until	
		#1 to the room because			ns of sustained compliance is	
		so fast. Nurse Aide #2		achieved th	en quarterly thereafter.	
		#1 dressed Resident #1,				
	•	hair, and removed her from			Action will be completed by	
		led about thirty minutes later		7/19/2024.		
	she (Nurse Aide #2) f					
		gain in her wheelchair				
		er hand on the front of his				
	pants and was attemp					
		Resident #2 was lying on				
	the bed on his back.					
		g was put into place for				
	-	om that evening. Nurse Aide				
	#2 stated Resident #2 undress, transfer, and	2 was able to dress and				

Facility ID: 080171

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	: 08/08/2024 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE : COMPI	LETED
	345566	B. WING		_	07/0	, 01/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHEALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
assistance at times an brief down herself. Nu Resident #1 had a hist sexual comments to of A Witness Statement w pm by Nurse Aide #1 r Nurse Aide #1 saw Re in the hallway and Res Resident #1 "come in r indicated Nurse Aide # and told her she shoul room and then she beg trays. Nurse Aide #2 of room and Resident #2 Resident #1 was lying was naked from the wa #1's brief and pants we humping Resident #1's trying to penetrate Res was not able to. Nurse Nurse #1 and she cam During an interview on Nurse Aide #1 she stat passing lunch meal tra Resident #2's room by when she came to the he was lying on the be with his legs over the s Resident #1 was on to stated she stayed just Resident #2's room. S an erection and he was in Resident #1. Nurse	her wheelchair without d could pull her pants and arse Aide #2 stated ory of behaviors of making ther residents. written on 6/16/2024 at 1:30 evealed the following: sident #1 and Resident #2 sident #2 whispered to my room". The statement #1 redirected Resident #1 d not go in Resident #2's gan passing lunch meal called her to Resident #2's was lying on his bed and on top of him. Resident #2 aist down and Resident ere down. Resident #1 was and Resident #2 was private parts and was also sident #1 with his penis, but e Aide called out to the ne to the room. 6/25/2024 at 1:14 pm with ted on 6/16/2024 she was nys when she was called to ' Nurse Aide #2. She stated door to Resident #2's room d perpendicular to the bed side edge of the bed and p of him. Nurse Aide #1 inside the doorway to She stated Resident #2 had s trying to insert his penis Aide #1 stated she yelled o the room but she had to	F 600				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/08/2024 APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION			LETED
		345566	B. WING _					C 01/2024
NAME OF P	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZI	P CODE		
PRUITTH	EALTH-UNION POINTE				510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 600	she returned to the ro minutes later and they Resident #2, dressed her from the room. N so shocked she did ne Resident #1 and Resi called to the room by An interview was come 6/25/2024 at 12:49 pr not assigned to Resid 6/16/2024. She state Resident #2's room by she was on the 400-h called out to her but s what Nurse Aide #1 w Aide #1 came down th come to Resident #2's she entered the room back perpendicular to was lying on top of hin Resident #1's brief an her ankles and Resider penetrate Resident #1 they assisted Resider removed her from the Resident #1 was foun again about 30 minute Nurse #1 stated Residen stated Resident #1 was the toilet and could pu and Resident #2 was and undressing.	hear her. She stated when om with Nurse #1 a few y assisted Resident #1 off of Resident #1 and removed urse Aide #1 stated she was of think about seperating dent #2 immediately when Nurse Aide #2. ducted with Nurse #1 on n and she stated she was ent #1 or Resident #2 on d she was called to y Nurse Aide #1. She stated all when Nurse Aide #1 he could not understand vas saying to her so Nurse he hall and asked her to s room. Nurse #1 stated and Resident #2 was on his the bed and Resident #1 m. Nurse #1 stated ed from the waist down and id pants were pulled down to ent #2 was attempting to 1's vagina. Nurse #1 stated in the sident #2's room es later by Nurse Aide #2.	F	800				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/08/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		-		C 01/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE		:	3510 WEST HIGHWAY 74			
				MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Nurse #2 who was as Resident #2 during th on 6/16/2024. Nurse facility and did not ret return call. On 6/25/2024 at 2:35 interview Resident #2 was not able to answe Resident #1 was obse 6/26/2024 at 10:00 ar to interview her regar 6/16/204. Resident # incident. During an interview of Director of Health Ser interviewed by phone 6/16/2024 at 1:10 pm Nurse #2 who reporte at 1:00 pm. The DHS found approximately 3 #2's room, by Nurse # had her hand on the f like she was trying to stated Resident #1 wa observation until after #2's room a second ti both Resident #1 and confused, but neither inappropriate touching stated she tried to inter	e 7 signed to Resident #1 and e 7:00 am to 7:00 pm shift #2 no longer worked for the urn messages left for a pm an attempt was made to and due to his cognition he er any questions. erved in her room on n and an attempt was made ding the incident on 1 did not remember the n 6/25/2024 at 4:45 pm the	F 600	D			
	6/25/2024 at 1:58 pm Resident #1 and Resi	r (NP) was interviewed on and she stated both dent #2 were cognitively nave the capacity to consent					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345566	B. WING			07	C 7/01/2024
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHI	EALTH-UNION POINTE				3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	to sexual contact.		F	60	0		
	6/25/2024 at 12:24 pr allegation of sexual to #1 and Resident #2 th approximately 1:00 pr aware of the second #1 and Resident #2 at	with the Administrator on m he stated he was aware of buching between Resident mat occurred on 6/16/2024 at m. He stated he was not incident between Resident and one-to-one observation t into place after the first two residents.					
	The Administrator wa jeopardy on 6/26/202 The facility provided t allegation of immedia	he following credible					
		nts who have suffered, or serious adverse outcome as npliance.					
	Resident #2's right to Both Resident #1 and	rotect Resident #1's and be free of sexual abuse. I Resident #2 had severe and were not capable of acts.					
	Resident #2's room. resident) was lying or female resident) lying was undressed from t #1's brief and pants v ankles. According to Nurse Aide #1 and No was humping Reside an erection and was t	PM Nurse Aide #1 entered Resident #2 (a male his bed with Resident #1 (a on top of him. Resident #2 the waist down and Resident were down around her the written statements of urse Aide #2, Resident #1 ht #2 and Resident #2 had trying to penetrate Resident b. Nurse #1 stated Nurse					

Facility ID: 080171

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		MEDICAID SERVICES				<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		
		245500	B. WING			С
		345566	B. WING			7/01/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
PRUITTH	EALTH-UNION POINTE			3510 WEST HIGHWAY 74		
	1			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	<b>a</b> 0	F 60	00		
1 000	e e i i i i i e i i pugi		FOL			
		her (she was in the hall),				
		e room to get her (Nurse #1) room (approximately 5				
		s notified) and observed				
		top of Resident #2 and				
		hand on his penis which was				
	erect and was trying	•				
		#1 stated Resident #2 had				
	not penetrated Resid	ent #1. Nurse #1 stated she				
	instructed Nurse Aide	e #1 and Nurse Aide #2 to				
		dent #2, and they dressed				
	her and wheeled her					
		1 from Resident #2's room,				
	they wheeled her dow					
	Resident #1 was a co	ig to the staff, monitoring				
	Resident #1 was a co	Diective enort.				
	Approximately 30 mir	nutes later, Resident #1 was				
		ent #2's room with her hand				
		ent #2's pants and when				
		doing she stated she was				
	fixing his pants. It wa	as at this time a dedicated				
	staff member was as	signed one to one to				
	Resident #1.					
	On 6/10/2024 Booid	ent #1's skin was assessed				
		e to help ensure there was				
		ecause of the incident.				
	-	sessment was done by the				
		6/2024. The assessment				
		airments. Resident #1 had a				
		5/2024 to remove her from				
		#2. On 6/16/2024 Resident				
		dicated 1:1 monitoring until				
		is her change in medication				
		haviors. On 6/20/2024				
		ident #2 were evaluated by				
		sident #1's medication, therapeutic medication, was				

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345566	B. WING				C / <b>01/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRIJITTHE	EALTH-UNION POINTE			;	3510 WEST HIGHWAY 74		
				l	MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	plan and resident pro- identified "touching of reviewed and revised medication changes a 6/27/2024, Resident # changes to his medic- care plan was reviewed to include sexual inap others to include atter another resident. The Administrator dire and Licensed Nurses the skin observations Interview for Mental S to identify any skin im (bruises, skin tears). score of 10 or above Department Manager Worker, Clinical Com Mix Director, Director Navigator) on 6/27/20 related to abuse, non- and mistreatment. The prevention, identificat any concerns are ider assessments and res includes notification the process or system fai adverse outcome from when the action will b On 6/26/2024, during	sed. Resident #1's care file were reviewed and ther residents" and was on 6/27/2024 to reflect the and 1:1 monitoring. On #2 did not have required any ation regimen, Resident #2's ed and revised on 6/27/2024 opropriate behaviors towards mpted sexual encounter with ected the Nurse Managers on 6/26/2024 to complete of all residents with a Brief Status (BIMS) of 9 or below upairments of unknown origin Residents with a BIMS will be interviewed by a (Administrator, Social petency Coordinator, Case of Health Services, Nurse 024 regarding any concerns consensual sexual abuse, he facility will initiate abuse ion and reporting policy if ntified from skin ident interviews. This o the State agencies, police tive services. e entity will take to alter the lure to prevent a serious in occurring or recurring, and e completed. an Ad Hoc Quality	F	600			
F 600	evaluated and increase plan and resident pro- identified "touching of reviewed and revised medication changes a 6/27/2024, Resident # changes to his medica care plan was reviewed to include sexual inap- others to include atter another resident. The Administrator dire and Licensed Nurses the skin observations Interview for Mental St to identify any skin im (bruises, skin tears). score of 10 or above Department Manager Worker, Clinical Com Mix Director, Director Navigator) on 6/27/20 related to abuse, non- and mistreatment. The prevention, identificat any concerns are ider assessments and ress includes notification the process or system fai adverse outcome fror when the action will b On 6/26/2024, during	sed. Resident #1's care file were reviewed and ther residents" and was on 6/27/2024 to reflect the and 1:1 monitoring. On #2 did not have required any ation regimen, Resident #2's ed and revised on 6/27/2024 opropriate behaviors towards mpted sexual encounter with ected the Nurse Managers on 6/26/2024 to complete of all residents with a Brief Status (BIMS) of 9 or below upairments of unknown origin Residents with a BIMS will be interviewed by a (Administrator, Social petency Coordinator, Case of Health Services, Nurse 024 regarding any concerns consensual sexual abuse, ne facility will initiate abuse ion and reporting policy if ntified from skin ident interviews. This o the State agencies, police tive services. e entity will take to alter the lure to prevent a serious n occurring or recurring, and e completed. an Ad Hoc Quality he Administrator and Clinical	F	600			

Facility ID: 080171

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 345566 NAME OF PROVIDER OR SUPPLIER			A. BUILDING	E CONSTRUCTION		FORM OMB NC (X3) DATE COMP	0: 08/08/2024 MAPPROVED 0: 0938-0391 SURVEY LETED C 01/2024
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Dietary Manager, Cas Coordinator, Financia Navigator, Admission Prevention of Abuse, Mistreatment, and Mis Procedures that inclu- non-consensual sexu- resident" and staff's h sexually inappropriate In the event of a resid nonconsensual sexua be provided a one-to- review is made by the Practitioner, Physician a removal plan for the a dedicated staff mem resident to prevent ful specific behavior. Th Services and/or Nurse designated staff mem Certified Nursing assi On 6/26/2024 the Clir Coordinator and Depa educating their respect the facility Prevention Exploitation, Mistreath Policy and Procedure abuse is non-consens type with a resident" a awareness of sexually between residents. A have a sexual relation will be evaluated by the	s (Director of Health ker, Environmental Services, se Mix Director, Cas Mix I Counselor, Nurse s Director) on the facility's Neglect, Exploitation, sappropriation Policy and des "sexual abuse is al contact of any type with a eightened awareness of e actions between residents. lent-to-resident I behavior, the residents will one staff member until e provider (Nurse h, Psychiatrist) to determine e one-to-one. One-to-one is her assigned to the rther occurrences of a e Director of Health e Managers assign the bers by identification on the gnment sheet. hical Competency artment Managers began ctive department related to of Abuse, Neglect, ment and Misappropriation s that includes "sexual sual sexual contact of any and staff's heightened y inappropriate actions iny resident voicing desire to aship with another residents mpacity to make an	F 600				

Facility ID: 080171

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/08/ FORM APPRC OMB NO. 0938-(
TATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		345566	B. WING		C 07/01/2024
NAME OF PF	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZI		
оринттис	ALTH-UNION POINTE		351	0 WEST HIGHWAY 74	
PROTTINE	ALTH-UNION FOINTE		мо	NROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
F 600	behavior, or an obser staff's prior knowledg residents with BIMS as cognitive capacity to the staff members rep Licensed Nurse, who Manager and Adminis provided a one-to-on- is made by the provid Physician, Psychiatris plan for the one-to-on- dedicated staff member to prevent further occ behavior. Staff member 6/27/2024 will be edu scheduled shift. The Competency Coordin ensuring all staff are Facility Staff who are receive the in-person are not scheduled to education by their De Administrator upon ne education for all new Clinical Competency Administrator and/or	anonconsensual sexual rved sexual act without the e of consent of both score of 10 or greater with consent to the sexual act, port the behavior to the reports to the Nurse strator. The residents will be e staff member until review der (Nurse Practitioner, st) to determine the removal ne. One-to-one is a ber assigned to the resident currences of specific bers not educated by located prior to their next Administrator and/or Clinical ator are responsible for educated by 6/27/2024. scheduled to work will education; Facility Staff who work will receive verbal none with review of epartment Manager and/or ext scheduled shift. This added to the general ly hired staff provided by the Coordinator. The	F 600		
	review. Alleged date of imme 6/29/2024.	diate jeopardy removal:			
	Immediate Jeopardy	ty's Credible Allegation of removal was completed on were conducted with the			

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						O. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · ·	E SURVEY
	CONTRECTION	DENTIFICATION NOMBER.	A. BUILDING	G	001	
		0.45500				С
		345566	B. WING			7/01/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74		
			MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 13	F 60	00		
1 000			FOU			
	Administrator, Director of Health Services, Nurse Aides, Nurses, Social Worker, Dietary Staff,					
		Maintenance Director,				
		Coordinator, and Assistant				
		nd staff were able to identify				
	-	abuse, and that sexual				
		sual sexual contact of any				
		ated residents should be				
	removed from abusiv	e situations and monitored				
	to ensure no further a	abuse occurs. The facility				
		ssment completed on				
		nt #1 and she did not have				
		. Resident #1's room was				
		24 to remove her from the				
		Resident #2. Resident #1				
		o-one observations and was				
		validation on one-to-one w of Resident #1's medical				
		was seen by the Nurse				
		2024 and was seen by				
		on 6/20/2024 and her				
		edication, paroxetine was				
		sed. Resident #1's Care				
		nd updated on 6/27/2024 to				
		o-one monitoring and a				
		otherapeutic medication.				
	Resident #2's care pl	an was reviewed and				
		d on 6/27/24. The facility				
		sment forms for residents				
		lower and documentation of				
		ents with a BIMS higher than				
		her residents were assessed				
		completed on 6/28/204. The				
		a copy of the minute notes				
		uality Assurance Meeting				
		Quality Assurance Team				
	-	's progress with their credible f correction. The facility's				

Facility ID: 080171

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	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	MPLETED
						С
		345566	B. WING		0	7/01/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page was validated.	e 14	F 60	00		
F 607 SS=J	Develop/Implement A		F 60	70		7/19/24
	§483.12(b) The facilit implement written pol	y must develop and icies and procedures that:				
	§483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re	ion of residents and				
		§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and				
	§483.12(b)(3) Include paragraph §483.95,	e training as required at				
	§483.12(b)(4) Establis QAPI program require	sh coordination with the ed under §483.75.				
	facilities in accordance Act. The policies and	e reporting of crimes funded long-term care we with section 1150B of the procedures must include the following elements.				
		ting a conspicuous notice of lefined at section 1150B(d)				
	retaliation, as defined (2) of the Act.	hibiting and preventing at section 1150B(d)(1) and is not met as evidenced				
	Based on record revi interviews the facility	iew, observations, and staff failed to implement their g to immediately implement		Resident #1 was placed on 1:1 monitoring. An initial investigat regarding this incident has been	ion report	

Event ID: 112911

Facility ID: 080171

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•=	S FOR MEDICARE & I					D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COM	E SURVEY PLETED
		345566	B. WING		C 07/01/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07	01/2024
				3510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		OULD BE	(X5) COMPLETIO DATE
E 607	Continued From page	15	F 607	,		
F 607	Nurse Aide #2 observ severe cognitive impar Resident #2) engaged did not have the capa staff did not immedia to provide protection f residents remained en until Nurse #1 arrived Nurse Aide #1 and Nur residents. Approximar residents were separa observed Resident #1 with her hands on the was "attempting to ren the facility failed to im for reporting and inve- for 2 of 4 residents (R #2) reviewed for alleg Immediate Jeopardy R the facility failed to im protective measures of Resident #2 were obs activity that they did n capacity to consent to removed on 6/29/2022 and implemented an a allegation of Immedia facility remains out of scope and severity let	when Nurse Aide #1 and red two residents with airment (Resident #1 and d in sexual activity that they city to consent to and the tely separate the residents from further abuse. The ngaged in the sexual act at the room and instructed urse Aide #2 to separate the ately 30 minutes after the ated, Nurse Aide #2 I back in Resident #2's room front of his pants and she move them." Additionally, plement their abuse policy stigating the sexual abuse tesident #1 and Resident ations of abuse. began on 6/16/2024 when mediately implement when Resident #1 and served engaging in sexual to thave the cognitive b. Immediate Jeopardy was 4 when the facility provided acceptable credible te Jeopardy removal. The compliance at a lower vel of "D" (no harm with n minimal harm that is not	F 607	<ul> <li>submitted to NC Department of H and Human Services Regulation department on 6/26/24. The incid also been reported to the County Protective Services and the local department on 6/26/24.</li> <li>All other residents have the poter affected by the deficient practice. The Facility Administrator conduc audit of all other abuse allegation the past six months to ensure interventions were immediately implemented to protect the reside prevent further abuse, that the all were reported as required and we investigated thoroughly. Any ide discrepancies will be addressed at to the abuse protocol up to and ir notification to Department of Hea Human Services, Adult protective and local police department (6/27) issues were noted during this aud</li> <li>An Ad Hoc Quality Assessment a Performance Improvement meeti held to discuss and review its pol abuse identification and abuse prand reporting (6/26/24). Attendeed included the Administrator, Direct Nursing Services, Social Services Mix Nurse, Nurse Navigator, Bus</li> </ul>	ent has Adult Police ntial to be eted an as within ents and legations ere ntified according ncluding lth and e services 7/24). No dit. nd ng was icies on revention es tor of s, Case	
	systems put into place Findings included: The facility's Abuse, N	e are effective.		Office, and Admissions Director. Committee concluded the policy a procedure had not been followed committee reviewed the facility a on Abuse Identification as well as	The and . The s policy	

Facility ID: 080171

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		ND HUMAN SERVICES MEDICAID SERVICES			FORI	D: 08/08/202 M APPROVE D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COME	E SURVEY PLETED
		345566	B. WING		C 07/01/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
040.15		ATEMENT OF DEFICIENCIES				()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 607	Continued From page	e 16	F 607	7		
	policy, last revised or following: Sexual ab	n 1/11/2024, included the use is non-consensual		how to identify and address alleg abuse.	gations of	
	sexual contact of any type with a resident. Any person observing or identifying any signs or symptoms of abuse was to report it to the Administrator as soon as possible. The Administrator was to inform and designate other staff members to assist in the investigation as needed. If there was an occurrence or an allegation involving resident abuse, the facility			The Clinical Competency Coord completed education with facility Managers and Department Man (Dietary, Housekeeping, and	/ Nurse	
				Environmental Services) on abu identification and abuse prevent reporting, to ensure they were p	ion and	
	would ensure that pre protect the health and	ecautions were taken to d safety of the resident		and able to disseminate informa their staff (6/28/2024). Departm Managers (Dietary, Housekeepi	tion to ent	
	during the course of and following the investigation. The Administrator or their designee should notify the state agency and other agencies			Environmental Services) along v Clinical Competency Coordinato educated their staff on Abuse	vith the	
	The initial report to the include the nature an	e regulations and state law. e state agency should d extent of any injuries. The vas to be submitted to per		Identification as well as Abuse P to ensure understanding of how and address allegations of abus	to identify	
	state requirements.	nitted to the facility on		who have not received education 6/28/24 will be provided education the beginning of their next sched	n by on prior to	
	3/15/2023 and her dia with psychosis and a	agnoses included dementia cognitive communication		Systemically, in addition to the fa	acility⊡s	
	deficit. A quarterly Minimum	Data Set assessment dated		general orientation discussion of and neglect, an annual review of facility Abuse Identification as we	f the	
		esident #1 was severely		Abuse Prevention Policy to ensu understanding of how to identify address allegations of abuse (6/	and	
		nitted to the facility on agnoses included a history of enia.		This education has also been ac reviewed during general oriental newly hired staff and reviewed.	ded and	
		essment dated 6/5/2024 2 was severely cognitively		To monitor the performance of the systemic change, interviews will conducted for residents with a B of 10 or above and skin checks	be IM score	
	A Witness Statement	dated 6/16/2024 at 1:30 pm		completed for residents with BIN		

Facility ID: 080171

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			0			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	ATE SURVEY
			A. BUILDING			
		345566	B. WING			С
		545566	STREET ADDRESS, CITY, STATE, ZIP CODE			07/01/2024
NAME OF P	ROVIDER OR SUPPLIER				ODE	
PRUITTH	EALTH-UNION POINTE			3510 WEST HIGHWAY 74		
	1			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	e 17	F 60	7		
	completed by Nurse A			of 9 or below to identify any	notential	
		She entered Resident #2's		areas of abuse. These audi		
	U U	dent #2 lying on his back		conducted for ten residents		
		dicular to the bed with his		four weeks. Thereafter these	-	
	legs hanging over the			conducted for eight residen		
		g on top of Resident #2.		three months. Thereafter th	•	
		naked from the waist down		be conducted for eight resid	dents quarterly	
	and Resident #2 had	one hand on his penis and		unless reviewed and revise		
		penis in Resident #1, and he		Quality Assurance Performa		
	was touching her priv	ate parts with his other		Improvement Committee.		
	hand. Nurse Aide #2	called out to Nurse Aide #1				
	and Nurse Aide #1 ca	alled out to Nurse #1. When		Administrator to monitor all	reportable	
	Nurse #1 arrived at th	ne room they assisted		incidents weekly for timely a	and complete	
	Resident #1 off Resid	lent #2, dressed her, and		submission to all regulatory	agencies. The	
	removed her from the	e room.		Director of Health Services	will report the	
				analysis of the resident inte	rviews and	
		y phone with Nurse Aide #2		skin observations to the fac	• •	
		) am she stated she was		Assurance and Performance		
		#1 and Resident #2 on		Improvement Committee m	-	
		) am to 7:00 pm shift. She		three months of sustained of	•	
		ident #1 in Resident #2's		achieved then quarterly the		
		stated Resident #2 was		administrator will report the	•	
	lying on his back on h	-		reportable incidents to the f	• •	
		bed and his legs hanging		Assurance and Performance		
		ed with Resident #1 lying on		Improvement Committee m		
		le #2 stated Resident #2 had		three months of sustained of		
		ad one hand on his penis		achieved, then quarterly the	erealter.	
		etrate Resident #1's vagina ul. She stated she was just		Corrective Action will be co	mplotod by	
		Resident #2's room when		7/19/2024	inpleted by	
	-	and Resident #2 and she				
		ide #1 who came to the				
		Nurse Aide #1 then called				
		me to the room. Nurse Aide				
		#1 left the room to get				
		ly gone a few minutes				
		e to the room. Nurse Aide				
		separate the residents prior				
		from Nurse Aide #1 and they				

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C
345566 B. WING	07/01/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL	
3510 WEST HIGHWAY 74	
PRUITTHEALTH-UNION POINTE MONROE, NC 28110	
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CO           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 607       Continued From page 18       F 607         (Nurse Aide #2 and Nurse Aide #1) did not separate Resident #1 and Resident #2 before they called for Nurse #1. When asked why, she stated she did not think about separating the residents because everything happened so fast. Nurse Aide #2 stated Nurse #1 instructed her to help remove Resident #1 from the bed, get her dressed and remove her from the room. Nurse Aide #2 stated no interventions or monitoring was implemented for Resident #1 or Resident #2 after this incident. She indicated about thirty minutes later she found Resident #1 back in Resident #2's room. Resident #1 was in her wheelchair beside Resident #2's bed and Resident #2 was lying on his back in bed. Resident #1 had her hand on the front of his pants and was attempting to remove them. Nurse Aide #2 stated she notified Nurse #1 of Resident #1 coming back into Resident #2's room and she (Resident #1) was removed from the room again. Nurse Aide #2 stated between 6:30 pm and 7:00 pm on 6/16/2024 Resident #1 was put on one-to-one observation, and she did not know why Resident #1 was not put on one-to-one observation sooner. Nurse Aide #2 indicated no additional interventions or monitoring were implemented for either resident prior to the one-to-one observation of Resident #1.         A Witness Statement written on 6/16/2024 at 1:30 pm by Nurse Aide #1 revealed the following: Nurse Aide #1 called her to Resident #2 mas nubsing Resident #2 was lying on his bed and Resident #2 was lying on pot him. Resident #2 was naked from the wasit down and Resident #1's brief and pants were down. Resident #1 was naked from the waist down and Resident #1's brief and pants were down. Resident #1 was humping Resident #1's private parts and was also trying to penetrate Resident #1 with his penis, but was not able to. Nurse Aide called out to the	

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	S FOR MEDICARE &					IO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · ·	TE SURVEY MPLETED		
						С		
		345566	B. WING		0	7/01/2024		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		E			
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74				
			M	ONROE, NC 28110				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 607	Continued From page	e 19	F 607					
	Nurse #1 and she car							
	to Resident #2's room 6/16/2024. She state Resident #2's room h the bed perpendicular hanging off the bed a top of him. Nurse Aid was trying to put his p was not able to. She Nurse #1, but Nurse # walked up the hallway 400-hall and got Nurs returned to the room of Resident #2 and R his hand and was still Resident #1. Nurse # Resident #1 off Reside from the room. Nurse were shocked and ne	she stated she was called						
	Aide #1 stated approv after the first incident, Resident #1's room a front of his pants and zipper. Nurse Aide #	urse #1 to the room. Nurse kimately 30 to 45 minutes Resident #2 was found in gain with her hand on the she was messing with his 1 stated after the second was put on one-to-one						
	6/25/2024 at 12:49 pr not assigned to Resid 6/16/2024. She state Resident #2's room b stated Nurse Aide #1	ducted with Nurse #1 on n and she stated she was lent #1 or Resident #2 on d she was called to y Nurse Aide #1. She had called to her but she hen Nurse Aide #1 came						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 08/08/2024 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING _			-	( 07/	C 01/2024
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
DDUUTTUE	ALTH-UNION POINTE			35	510 WEST HIGHWAY 74			
PRUITINE	ALTH-UNION POINTE			М	IONROE, NC 28110			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	¢	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 607	500-hall) and told her Resident #2's room. If approximately 5 minur Aide #1 came to get h Resident #2's room. If Resident #2's room an naked from the waist his back, with his legs and his legs hanging of was naked from the waist his back, with his legs and his legs hanging of was naked from the waist his brief and pants w Nurse #1 stated Resident #2 nesident #2, and Ress his penis, and he wass Resident #1. Nurse # an erection, but she d penetrate Resident #1 instructed Nurse Aide get Resident #1 off Re and removed her from she did not assess eit #2 for any injuries SI thirty minutes after the from Resident #2's roo Nurse Aide #2 in Resi hand on the front of R #1 stated Resident #1 observation after she room the second time what time the one-to-of Attempts were made of Nurse #2 who was as Resident #2 during th on 6/16/2024. Nurse	sident #2's room was on she needed to come to Nurse #1 stated it was tes from the time Nurse her until she arrived at Nurse #1 stated she entered nd observed Resident #2 down on his bed, lying on be perpendicular to the bed off the bed; and Resident #2 vaist down and Resident vere down to her ankles. dent #1 was lying on top of ident #2 had his hand on be trying to penetrate ef 1 stated Resident #2 had	F	307				

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	OF DEFICIENCIES	MEDICAID SERVICES		IPLE CONSTR			O. 0938-039	
	F CORRECTION	IDENTIFICATION NUMBER:	, í			· · · ·	IPLETED	
						С		
		345566	B. WING			07	07/01/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE			
				3510 WEST HIGHWAY 74				
PRUITIN	EALTH-UNION POINTE			MONROE	, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	Continued From non	- 24		07				
F 607	10		F 6	507				
	There was no eviden							
		that they were immediately						
		was no evidence the facility buse to the state agency,						
		rices, and law enforcement.						
	Addit 1 Totective Ociv							
	The Director of Healt	h Services (DHS) was						
		2024 at 4:45 pm and she						
		a call from Nurse #2 at 1:10						
	pm on Sunday, 6/16/	2024, and was told Resident						
	#1 was found in Resi	dent #2's room, Resident #1						
		esident #2 in his bed, and						
		unclothed from the waist						
		e immediately called the						
	-	ported Resident #1 and						
		empting to have sex and told vay to the facility to get						
		nd would keep him updated.						
		cate the Administrator gave						
		egarding the investigation						
	-	DHS stated she interviewed						
		e Aide #2, and Resident #1.						
	The DHS stated she	was not aware Resident #1						
		e not separated immediately						
		esident #1 was not put on						
		on immediately. The DHS						
		should have separated them						
		Resident #1 on one-to-one						
		tely to protect both residents. roximately 30 minutes after						
		rse Aide #2 found Resident						
		bom again. She stated						
		er, "she [Resident #1] had						
		nt of his [Resident #2] pants						
		take them off." The DHS						
	stated Resident #1 w	as put on one-to-one						
		second incident. The DHS						
	stated Resident #1 d							
		incident, but she took her to						

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	S FOR MEDICARE &					<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · /	TE SURVEY MPLETED
			A. BUILDING	i		<u>^</u>
		345566	B. WING			C
		545500		STREET ADDRESS, CITY, STATE, ZIP CODE		7/01/2024
NAME OF P	ROVIDER OR SUPPLIER					
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
0(0)15	CLIMMA DV CT				RECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 607	Continued From page	e 22	F 60	7		
		en 6:00 pm and 8:00 pm that	1 00			
		not have any bleeding when				
	wiped and she did no					
	· ·	as wiped. The DHS stated				
		terviews or assessments of				
	-	o ensure no one else was				
	sexually abused; she	did not do education with				
		e facility's sexual abuse				
		ot report the incident to the				
		Protective Services, or the				
		S stated the Administrator				
		eporting abuse to the state				
		tive Services, and the id not know why it was not				
	reported.					
		s interviewed on 6/26/2024				
	at 1:15 pm and he st					
		on of sexual abuse to the				
		Protective Services, and the				
		it authorities and he should estions of the staff when the				
		to him on 6/16/2024. The				
		since both residents were				
		nd were not aware they were				
		g, he had not considered the				
		abuse. He revealed he				
		Ild have reported the incident				
		t was able to consent to the				
	-	Administrator stated staff had				
		there was a second incident				
		Irning to Resident #2's room				
		separated Resident #1 and itely after the first incident.				
		ated he should have made				
	sure Resident #1 and					
	separated immediate					
		into place after the first				
	noo put					

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345566	B. WING			C 07/01/2024	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRUITTHI	PRUITTHEALTH-UNION POINTE				3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ЗE	(X5) COMPLETION DATE	
F 607	<ul> <li>#2's room the first tim were safe. He stated ensured there were in have been involved b interviewed and asse and he should have ecompleted with all the investigating, and prosexual abuse.</li> <li>The Administrator wa jeopardy on 6/26/202</li> <li>The facility provided the allegation of immedia and the should have ecompleted with all the investigating, and prosexual abuse.</li> <li>The Administrator wa jeopardy on 6/26/202</li> <li>The facility provided the allegation of immedia and the should have ecompleted with all the investigating, and prosexual abuse.</li> <li>The Administrator wa jeopardy on 6/26/202</li> <li>The facility provided the allegation of immedia and the should have ecompleted with all the investigating and the noncompleted the noncompleted the noncompleted the noncompleted the noncompleted the second the second the noncompleted the noncompleted the noncompleted the room, the lying on top of Residen the shand on his peniss trying to place his peristated Resident #2 to Resident #2 to Resident #2 and the noncompleted the room. Affrom Resident #2's room and Nurse Aide #2 to Resident #2 and the noncompleted the room. Affrom Resident #2's room and Nurse Aide #2's room and Nurse Nurse #1. Nurse #1 stated and Nurse Aide #2's room and Nurse Nurse #1 stated and Nurse Aide #2's room and Nurse Aide #2's room and Nurse Aide #2's room and Nurse Nurse #1 stated #1 from the room. Affrom Resident #2's room and Nurse Aide #2's room and Nu</li></ul>	te to ensure both residents he should have also o other residents that may y having the other residents ssed for any signs of abuse ensured education was a staff regarding reporting, tecting residents from s notified of immediate 4 at 10:36 am. he following credible te jeopardy removal. hts who have suffered, or serious adverse outcome as	F	607	7		

Facility ID: 080171

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/08/2024 APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345566	B. WING					C 01/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
PRUITTHE	ALTH-UNION POINTE				510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 607	Approximately 30 min again found in Reside on the front of Reside asked what she was of fixing his pants. It was dedicated staff memb Resident #1. The issues leading to its abuse policy for re- investigating the alleg sexual abuse was due The facility should hav abuse and reported to as outlined in its polic #2 do not have the ca decisions as it relates therefore, their inabilit could have resulted in decision to monitor Re- members observation assigned staff member did not protect Reside other and other facility the immediate protect further occurrences, F 1:1 observation on 6/7 will remain in place un Resident #1's physicial As a result of the faci abuse policy, local an notified, which compro-	<ul> <li>41 was a collective effort.</li> <li>utes later, Resident #1 was ent #2's room with her hand nt #2's pants and when doing she stated she was a at this this time a er was assigned to</li> <li>the facility not implementing porting, protecting, and ation of resident-to-resident e to a lapse in education.</li> <li>we treated this incident as o local and state agencies y. Resident #1 and Resident pacity to make rational to sexual intercourse; y to make this decision n injury or harm. The esident #1 by different staff versus a dedicated er was not appropriate as it ents #1 and #2 from each y residents. To help ensure ion of residents to prevent Resident #1 was placed on 16/2024. Direct monitoring ntil deemed safe by an.</li> <li>lity not implementing its d state agencies were not omised the protection of th investigation of the event. and following the facility II residents and their</li> </ul>	F	607				

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/08/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345566	B. WING _			_		C 01/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DOUNTTUE				35	510 WEST HIGHWAY 74			
PRUITIHE	EALTH-UNION POINTE			М	IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	25	F	607				
	Health and Human Se department on 6/26/2 been reported to the 0 Services and the loca 6/26/24.	omitted to NC Department of						
	an audit of all other all past six months to en immediately impleme and prevent further all were reported as requ thoroughly. Any idem addressed according and including notificat and Human Services, and local police depa Specify the action the process or system fai	buse allegations within the sure interventions were nted to protect the residents buse, that the allegations uired and were investigated tified discrepancies will be to the abuse protocol up to tion to Department of Health Adult protective services rtment. e entity will take to alter the lure to prevent a serious n occurring or recurring, and						
	process or system fai adverse outcome fror when the action will b An Ad Hoc Quality As Improvement meeting discuss and review its identification and abu Attendees included th Nursing Services, Soo Nurse, Nurse Navigat Admissions Director.	sessment and Performance was held 6/26/24 to						

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/08/2024 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	_		LETED
		345566	B. WING			( 07/	01/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110	ŀ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Abuse Identification a to ensure understand address allegations o On 6/26/24 the Clinica educated facility Nurs Department Manager and Environmental Se identification and abu to ensure they were p disseminate informati Department Manager and Environmental Se on Abuse Identificatio Prevention to ensure identify and address a 6/26/2024. The Clinic also began education on 6/26/24 on the fac abuse prevention and education included all staff. Those who have 6/28/24 will be provid beginning of their nex Administrator and/or 0 Coordinator maintains those who have been education has been c employees will be edu Competency Coordina Employee Orientation work on the units unti completed.	ved the facility's policy on s well as Abuse Prevention ing of how to identify and f abuse. al Competency Coordinator e Managers and s (Dietary, Housekeeping, ervices) on abuse se prevention and reporting, prepared and able to on to their staff. s (Dietary, Housekeeping, ervices) educated their staff n as well as Abuse understanding of how to allegations of abuse on al Competency Coordinator to all Facility Staff members lity abuse identification and I reporting policies. Staff I clinical and non-clinical e not received education by ed education prior to the t scheduled shift. The Clinical Competency s the employee roster of educated and who requires e staff do not work until ompleted. All new ucated by the facility Clinical	F 6	07			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	A. BUILDIN	COMPLETED	
					С
		345566	B. WING		07/01/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE
				3510 WEST HIGHWAY 74	
PRUITING	ALTH-UNION POINTE			MONROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLE IE APPROPRIATE DAT
F 607	Continued From page	- <b>9</b> 7	E G	07	
1 007			F 6	07	
		ty's credible allegation of			
		emoval was validated. The mentation of education			
		y regarding implementing ich included providing a			
		n, protection of the resident			
		residents, assessment of			
	the resident involved				
		resident, and reporting of all			
		to the state agency, adult			
		nd local police authorities			
		I on 6/26/2024. The facility			
		ntation of the sexual abuse			
	•	to the state agency, adult			
	protective services, a				
	-	lity provided documentation			
		servation by staff of Resident			
	#1 and observations	•			
		ons were completed during			
		ity's Administrator conducted			
	-	buse allegations within the			
		sure interventions were			
		place to protect residents			
		6/27/2024. An Ad Hoc			
	Quality Assessment a				
	•	g was held on 6/26/2024 and			
		the facility reviewed their			
	policies on abuse ide	5			
		ting. Facility staff were			
	interviewed and were	<b>c</b>			
		ntification of abuse and how			
	•	abuse. All the facility staff			
		about the types of abuse,			
		ort abuse to, how they should			
		and that residents should			
	-	ately if abuse is suspected.			
		ite jeopardy removal date of			

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