STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A onsite complaint investigation survey was conducted from 3/10/25 through 3/12/25. The exit was conducted by phone on 3/13/25. Therefore, the exit date was changed to 3/13/25. The following intakes were investigated: NC00228031, NC00228163, and NC00227927. 3 of the 4 complaint allegations resulted in deficiency. Intakes NC00228031, NC00228163, and NC00227927 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Noncompliance began on 3/2/25. The facility came back in compliance effective 3/9/25. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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 8/30/24 with diagnoses that included schizoaffective disorder, viral hepatitis C without	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

hepatic (liver) coma; viral hepatitis B without hepatic coma; Parkinsonism and psychophysiologic insomnia.

Review of the quarterly Minimum Data Set (MDS) assessment dated 1/25/25 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.

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 12/28/18 with diagnoses that included dementia, paranoid schizophrenia, and bilateral hearing loss.

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F 600	Continued From page 3	F 600		

Review of the quarterly MDS assessment dated 2/23/25 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

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F 600	Continued From page 4	F 600		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 600	Continued From page 5	F 600		

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 3/2/24 at 4:08 AM by Nurse #1 revealed Resident #2 was assessed due to resident-to-resident sexual abuse. No negative findings were observed.

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	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 600	Continued From page 6	F 600		

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

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	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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F 600	Continued From page 7	F 600		

Resident #1 was offered ice and water in his room by the NA at around 10:00 PM.

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

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	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 8	F 600		

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

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	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 9	F 600		

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.

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

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	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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F 600	Continued From page 10	F 600		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 11	F 600		

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 .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

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 3/2/25 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 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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F 600	Continued From page 19	F 600		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

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 also denied any pain, discomfort or concerns. Resident #2 was placed on 1:1 observation with a staff member until 7:24am on 3/2/25. To ensure there were no skin impairments or signs and symptoms of trauma from the incident, Resident #2 was further assessed by a Registered Nurse (RN) later that afternoon with no external signs and symptoms of pain, redness, bruising, swelling, bleeding, and the skin was completely intact, including the perineal area.

The medical provider for both Residents was notified. Family members of both residents were notified of the incident. Resident #1 was sent to Duke Emergency Department on 3/2/25 for psych evaluation at 12:50pm and returned to facility at 11:00pm with no new orders. The facility further consulted with Resident #1's psych provider and the result of the consultation was medication modification for Resident #1. Family for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

#2 refused two different attempts, via phone calls, for Resident #2 to be sent out to the emergency room for evaluation. The resident's sister stated she was content with facility assessment. Resident #2 was evaluated by the facility Nurse Practitioner on 3/3/25 with orders for blood work for both Resident #1 and Resident #2. Resident #2's facility psych provider, who was already followed by the psychiatric team, was notified of the incident with no orders at that time and was pending follow up on next routine visit. Care plans for Resident #1 and Resident #2 were updated to reflect inappropriate sexual behavioral interventions. Lab work ordered by Nurse Practitioner was completed and resulted for both residents, the Medical Director was notified of lab results for Resident #2 with no new orders. Resident # 1 was discharged from the facility on 3/6/2025 to the care of the resident's family, per family's choice with home health. Resident #1 was on 1:1 staff observation until time of discharge.

Upon further investigation, through video footage, it was identified that Resident #1 was observed earlier by Certified Nursing Assistant (CNA) # 1 in the hallway unclothed with linen wrapped around him, but CNA #1 did not redirect the resident. An interview with CNA #1 revealed the CNA was responding to an alarm or beeping which took his focus away from responding to Resident #1.

It was also identified that on 3/2/15, Resident #1 entered Resident #3's room and exited the room without any interaction with Resident #3 as evidenced by staff reported that the resident was asleep, fully clothed, with no concerns voiced to them and the social worker. Furthermore, Resident # 3 had a Brief Interview for Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

Status (BIMS) score of 8 and would have been able to indicate if someone was inappropriate with her. Resident #3 was assessed by a Registered Nurse with no abnormalities noted such as bruising, pain, redness, swelling, bleeding and skin impairment to include the perineal area on 3/2/25, to ensure there was no skin impairment.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

Nurse #1 and CNA # 1 were both suspended pending investigation on 3/3/2025. Nurse # 1 was nurse assigned to that hall was to Resident #1, #2 and #3. Nurse # 1 was observed via camera with chair lowered, looking down, not visually observing her unit nor her Certified Nursing Assistant assigned to her hall. CNA # 1 was observed via camera walking past Resident # 1 while was naked in the hallway.

The Social Worker completed an abuse questionnaire to all residents who were alert and orientated with a Brief Interview for Mental Status Score (BIMS) of 10 and above. This questionnaire included how they felt about their safety, care needs and who they need to contact at the facility with concerns. This audit was completed on 3/2/25, with no negative response which would warranty further follow up.

For those residents who were determined to be to be cognitively impaired or with a BIMS score below 10, body audits were completed by the RN wound nurse to identify any signs of abuse. This audit was completed on 3/4/25. No skin impairment was found which required further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23 investigation Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/2/25, RN Clinical Competency Coordinator and RN Unit manager began education to all facility staff related to the facility abuse and neglect prevention policy and procedure, that included sexual abuse and non-consensual contact to all facility staff; the need for staff's heightened awareness of sexually inappropriate actions between residents, non-consensual sex that includes any sexual act that happens without the consent to further include sexual intercourse, fondling and penetration. Non-Consensual sex is also when the victim is unable to give consent. The education also included all staff who are required to redirect residents that are observed to be inappropriately dressed or without clothing. This is the responsibility of all staff. Education included caveat that residents with dementia and/or behaviors that may be sexual in nature, must have immediate intervention that include separation of residents, staff 1:1, immediately and call for help, summoning charge nurse, reporting to Director of Nursing, Administrator. Education was conducted for all staff on 3/2/25. Any staff member who did not receive the education by 3/2/25 was not allowed to work until they received the education. This education will be added to the curriculum for all newly hired staff during general orientation; the Director of Nursing or Assistant Director of Nursing will provide the education and monitor who has received the education to ensure all staff receive the education.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

The Social Worker will interview 3 random residents with a BIMS score of 10 and higher 3x's/ week for 2 weeks, then 3 random residents weekly x's 4 weeks, then 3 random residents monthly x's 3 months unless reviewed and revised by the Quality Assurance and Performance Improvement committee.

The Director of Health Services will perform body audits on residents with BIMS 9 and below. Three random residents will be audited 3 x's/week for 2 weeks, then three random residents weekly for 4 weeks, then three random residents monthly for 3 months unless reviewed and revised by the Quality Assurance and Performance Improvement (QAPI) committee.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Health Services will report on the analysis of the resident interviews and skin observations to the facility Quality Assurance and Performance Improvement (QAPI)monthly until three months of sustained compliance is achieved quarterly thereafter. On 3/2/25, the administrator, Interim Director of Health Service (DHS) and Medical Director met via phone to discuss the incident. On 3/3/25, a meeting with the interdisciplinary team which included the members of the QAPI team was held to discuss and was and review the events, discuss actions items to date, current monitoring and audit tools and the findings of the investigation. A QAPI was held with the interdisciplinary team to include the medical director via phone. This ad hoc meeting was a wrap up to provide conclusion to the IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

Team on findings and actions taken regarding the incident. No further incidents or concerns identified within the facility.

Allegation of immediate jeopardy removal and compliance date: 3/9/25.

The corrective action plan was validated onsite on 3/12/25. It was verified through staff interviews that Residents #1 and #2 were immediately separated and assessed for injury. Resident #1 was placed on 1:1 supervision and documentation of supervision verified. Resident #2 was on 1:1 supervision on 3/2/24 till 7:24 AM. Validated by supervision documentation review. Body Audit Forms and Head to toe body assessments completed on 3/2/24 for Resident #1, Resident #2 were reviewed and no identified concerns. Care plan for Resident #1 and Resident #2 were reviewed and revised. Nurse #1, NA #1 and NA #2 were interviewed, and they indicated they were suspended during investigation. Nurse #1 and NA #2 stated they were terminated. NA #2 indicated she returned back to work after receiving education and disciplinary action. Interview with Resident #2's RP revealed the resident was at her baseline and did not exhibit any change in her moods or behavior. Resident #2 lab results were reviewed by the physician. Resident #2 was alert and pleasant. During an interview, the Medical Director indicated he had a meeting with Administrator and interim DON regarding the incident on 3/2/24 via phone. He also indicated the IDT team met for an ad hoc meeting and he was available via phone. Multiple alert and oriented residents were interviewed during the survey, and they indicated they felt safe at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/13/2025

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F 600	Continued From page 26 facility and were able to state whom to report for any abuse. Audit tools were reviewed. Audit report indicated all cognitively intact residents were interviewed to ensure that no other incidents of sexual abuse had occurred. No other incidents were reported. Audit tools were reviewed and validated that all cognitively impaired residents were assessed for signs of sexual abuse with no negative findings. A sample of staff from various shifts that included nurses, and nursing assistants were interviewed regarding in-service training. All staff stated they received in-service training as indicated in the corrective action plan to include abuse/neglect, sexual abuse training, reporting and assisting residents when inappropriately dressed. Nurses and NAs also reported receiving education on rounding for resident. NAs indicated they received education regarding always staying in their assigned halls and visible to ensure timely response. The audit forms that were utilized for monitoring that the systems put in place were effective were reviewed and validated. Skin assessments and resident interviews were conducted as designated in the corrective action plan. The facility's corrective action plan's compliance date of 3/9/25 was validated. Immediate jeopardy removal date of 3/9/25 was validated.	F 600		