

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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  An on site complaint investigation survey was conducted 6/25/2024 through 6/26/2024. The facility's credible allegation of immediate jeopardy removal was validated on 7/1/24. Therefore, the exit date was changed to 7/1/2024. The following intake was investigated: NC00282402. One (1) of 1 allegation resulted in a deficiency. Intake NC00282402 resulted in immediate jeopardy. Immediate Jeopardy was identified at:  CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.12 at tag F607 at a scope and severity of J.  The tags F600 and F607 constituted Substandard Quality of Care.  Immediate Jeopardy began on 6/16/2024 and was removed on 6/29/2024. 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		7/19/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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	<p>Continued From page 1</p> <p>physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and Nurse Practitioner interviews the facility failed to protect Resident #1's and Resident #2's right to be free from sexual abuse. On 6/16/24 staff (Nurse Aide #1, Nurse Aide #2, and Nurse #1) observed Resident #1 (female) in Resident #2's (male) room. Resident #2 was lying on his back on the bed naked from the waist down and Resident #1 was on top of him with her brief and pants down at her ankles. Resident #2 had one hand on his erect penis and was "trying to insert his penis" in Resident #1, and he was touching her "private parts" with his other hand. Approximately 30 minutes after the residents were separated, Nurse Aide #2 observed Resident #1 back in Resident #2's room with her hands on the front of his pants and was "attempting to remove them". Resident #1 and Resident #2 had severe cognitive impairment and did not have the capacity to consent. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause trauma and fear. This deficient practice affected 2 of 4 residents reviewed for abuse.</p> <p>Immediate Jeopardy began on 6/16/2024 when the facility failed to protect Resident #1's and Resident #2's right to be free from sexual abuse. Immediate Jeopardy was removed on 6/29/2024 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (no harm with potential for more than minimal harm</p>	F 600	<p>Nurse Aide #1 and Nurse Aide #2 assisted Resident #1 off Resident #2. Resident#1 was dressed and wheeled to her room. Resident #1 was also placed on 1:1 monitoring. Resident #1's skin assessment was completed on 6/19/2024. There were no findings. Resident #2's skin assessment was completed on 6/26/2024. There were no findings. Resident #1 has remained on 1:1 since the incident date. Resident #1 and Resident #2 were evaluated by their psychiatrist on 6/20/24. Resident #1's medications paroxetine, a psychotherapeutic medication, was evaluated and increased. No changes were made to resident #2's medication regimen. Resident #1's care plan and resident profile and was revised on 6/27/24 to reflect the medication changes and 1:1 monitoring. Resident #2's care plan was revised on 6/27/24 to include sexually inappropriate behavior towards others. Resident #1 will remain on 1:1 monitoring until further evaluated and released by the facility psychiatrist.</p> <p>All other residents have the potential to be affected by the deficient practice.</p> <p>To identify other residents having the potential to be affected by the same deficient practice, the facility completed interviews with all alert and oriented residents with BIMS scores of 10 or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 2</p> <p>that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 3/15/2023 and her diagnoses included dementia with psychosis and a cognitive communication deficit.</p> <p>A quarterly Minimum Data Set assessment dated 6/5/2024 indicated Resident #1 was severely cognitively impaired and required moderate assistance with transfers, used a wheelchair for mobility in the facility, and had not had behaviors.</p> <p>Resident #1's care plan was reviewed and a care planned problem dated 2/10/2024 and updated on 6/11/2024 indicated Resident #1 required various degrees of assistance with activities of daily living and should be allowed to attempt activities of daily living before being assisted and required incontinence care as needed and during care rounds. A care plan problem dated 8/1/2023 indicated Resident #1 had physical and verbal behaviors of attempting to touch others (residents and visitors), yelling out, resisting care, and not being easily redirected during behaviors. The care plan problem indicated staff would assess whether the behavior endangers the resident or others and intervene if necessary.</p> <p>Resident #2 was admitted to the facility on 11/8/2023 and his diagnoses included a history of stroke and schizophrenia.</p> <p>A quarterly MDS assessment dated 6/5/2024 which indicated he was severely cognitively</p>	F 600	<p>higher to inquire if they had ever been physically, verbally, sexually, mentally abused or exploited, to determine if at any point facility staff had not met their needs, and if they had ever witnessed abuse or neglect (6/28/2024). For those residents determined to not be cognitively intact and/or with a BIMs score of lower than 10, body audits were completed to identify any signs of abuse or neglect, and to determine if residents had any injuries of unknown origin (6/28/2024). Any adverse findings were reported to the Administrator, and became subject to the facility's Policies, Procedures, and Protocols for Abuse. One bruise noted, investigation completed, and findings sent to all regulatory agencies as required.</p> <p>To ensure that the deficient practice will not recur, an Ad Hoc Quality Assurance and Performance Improvement was held (6/26/2024). Attendees Meeting attendees included the Administrator, Clinical Competency, Director of Health Services, Social Worker, Environmental Services, Dietary Manager, Case Mix Director, Case Mix Coordinator, Financial Counselor, Nurse Navigator, and Admissions Director, on the facility's Prevention of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation Policy and Procedures. This review also included education to reiterate that sexual abuse is non-consensual sexual contact of any type.</p> <p>Additionally, in the event of a resident-to-resident nonconsensual sexual behavior, or an observed sexual</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 3</p> <p>impaired; was independent with transfers, walking, and toileting; and he had not behaviors.</p> <p>Resident #2's care plan was reviewed and a care plan for 1/6/2024 stated he was independent with transfers, walking, and toileting and had verbal behaviors of threatening others, screaming at and cursing others, and episodes of fighting others. The interventions for Resident #2's care plan indicated staff would avoid overstimulation and maintain a calm environment.</p> <p>Review of Resident #1's medical record revealed a Nurse's Progress Note written by the Director of Health Services (DHS) on 6/16/2024 at 5:30 pm which stated Resident #1 exhibited behaviors.</p> <p>A Nurse's Progress Note written by the DHS on 6/16/2024 at 5:35 pm in Resident #2's electronic record dated 6/16/2024 at 5:35 pm indicated Resident #2 exhibited behaviors.</p> <p>A Witness Statement written on 6/16/2024 at 1:30 pm by Nurse Aide #2 revealed the following: She entered Resident #2's room and found Resident #2 lying on his back with his body perpendicular to the bed with his legs hanging over the side of the bed and Resident #1 was lying on top of Resident #2. Both residents were naked from the waist down and Resident #2 had one hand on his penis and was trying to put his penis in Resident #1, and he was touching her private parts with his other hand. Nurse Aide #2 called out to Nurse Aide #1 and Nurse Aide #1 called out to Nurse #1. When Nurse #1 arrived at the room they assisted Resident #1 off Resident #2, dressed her, and removed her from the room.</p> <p>Nurse Aide #2 was interviewed on 6/26/2024 at</p>	F 600	<p>act without the staff's prior knowledge of consent of both residents with BIMS score of 10 or greater with cognitive capacity to consent to the sexual act, the residents will be separated, the staff members will report the behavior to the Licensed Nurse, who reports to the Nurse Manager and Administrator. The residents will be provided with a one-to-one staff member until a review is made by the provider (Nurse Practitioner, Physician, Psychiatrist) to determine a removal plan for the one to one. The Administrator and/or Clinical Competency Coordinator Educated began educating all staff on the facility Prevention of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation Policy and Procedures. Facility Staff who are scheduled to work receive in-person education by the Clinical Competency Coordinator, their respective Department Manager, or Administrator. Staff not scheduled to work received verbal education over the phone from the Clinical Competency Coordinator, their respective Department Manager, or the Administrator. This education has also been added to the general orientation for newly hired staff and reviewed by the Clinical Competency Coordinator</p> <p>Systemically, in addition to the facility's general orientation discussion on abuse and neglect, an annual review of the facility Prevention of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation Policy and Procedures will be conducted (6/28/2024). This education has also been added and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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 4 10:00 am by phone and she stated she worked on 6/16/2024 and found Resident #1 in Resident #2's room. She stated Resident #2 was lying on his back on his bed with his legs perpendicular to his bed and his legs hanging over the side of the bed with Resident #1 lying on top of him. Nurse Aide #2 stated Resident #2 had an erection and he had one hand on his penis and was trying to penetrate Resident #1's vagina but was not successful. She stated she was just inside the doorway to the room when she saw what was happening she called out to Nurse Aide #1 who came to the room. Nurse Aide #2 stated they did not separate Resident #1 and Resident #2 before they called for Nurse #1. She indicated then Nurse Aide #1 called out to Nurse #1 to come to the room. Nurse Aide #2 stated Nurse Aide #1 left the room to get Nurse #1 and it was only a few minutes before Nurse #1 came to the room. She indicated she remained standing inside the doorway to the room until Nurse #1 got to the room. Nurse Aide #2 stated she did not think about seperating Resident #1 and Resident #2 before calling Nurse #1 to the room because everything happened so fast. Nurse Aide #2 stated she and Nurse #1 dressed Resident #1, put her in her wheelchair, and removed her from the room. She revealed about thirty minutes later she (Nurse Aide #2) found Resident #1 in Resident #2's room again in her wheelchair beside his bed with her hand on the front of his pants and was attempting to remove them. Nurse Aide #2 stated Resident #2 was lying on the bed on his back. Nurse Aide #2 stated one-to-one monitoring was put into place for Resident #2 at 6:00 pm that evening. Nurse Aide #2 stated Resident #2 was able to dress and undress, transfer, and walk without assistance and Resident #1 could transfer herself to the	F 600	reviewed during general orientation for newly hired staff and reviewed.  To monitor the performance of this systemic change, interviews will be conducted for residents with a BIM score of 10 or above and skin checks will be completed for residents with BIMS score of 9 or below. These audits will be conducted for ten residents weekly for four weeks. Thereafter these audits will be conducted for eight residents monthly for three months. Thereafter these audits will be conducted for eight residents quarterly unless reviewed and revised by the Quality Assurance Performance Improvement Committee.  The Director of Health Services will report the analysis of the resident interviews and skin observations to the facility Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is achieved then quarterly thereafter.  Corrective Action will be completed by 7/19/2024.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 5</p> <p>commode and back to her wheelchair without assistance at times and could pull her pants and brief down herself. Nurse Aide #2 stated Resident #1 had a history of behaviors of making sexual comments to other residents.</p> <p>A Witness Statement written on 6/16/2024 at 1:30 pm by Nurse Aide #1 revealed the following: Nurse Aide #1 saw Resident #1 and Resident #2 in the hallway and Resident #2 whispered to Resident #1 "come in my room". The statement indicated Nurse Aide #1 redirected Resident #1 and told her she should not go in Resident #2's room and then she began passing lunch meal trays. Nurse Aide #2 called her to Resident #2's room and Resident #2 was lying on his bed and Resident #1 was lying on top of him. Resident #2 was naked from the waist down and Resident #1's brief and pants were down. Resident #1 was humping Resident #2 and Resident #2 was rubbing 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 Nurse #1 and she came to the room.</p> <p>During an interview on 6/25/2024 at 1:14 pm with Nurse Aide #1 she stated on 6/16/2024 she was passing lunch meal trays when she was called to Resident #2's room by Nurse Aide #2. She stated when she came to the door to Resident #2's room he was lying on the bed perpendicular to the bed with his legs over the side edge of the bed and Resident #1 was on top of him. Nurse Aide #1 stated she stayed just inside the doorway to Resident #2's room. She stated Resident #2 had an erection and he was trying to insert his penis in Resident #1. Nurse Aide #1 stated she yelled at Nurse #1 to come to the room but she had to leave the room to get Nurse #1 because she</p>	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 6</p> <p>(Nurse #1) could not hear her. She stated when she returned to the room with Nurse #1 a few minutes later and they assisted Resident #1 off of Resident #2, dressed Resident #1 and removed her from the room. Nurse Aide #1 stated she was so shocked she did not think about seperating Resident #1 and Resident #2 immediately when called to the room by Nurse Aide #2.</p> <p>An interview was conducted with Nurse #1 on 6/25/2024 at 12:49 pm and she stated she was not assigned to Resident #1 or Resident #2 on 6/16/2024. She stated she was called to Resident #2's room by Nurse Aide #1. She stated she was on the 400-hall when Nurse Aide #1 called out to her but she could not understand what Nurse Aide #1 was saying to her so Nurse Aide #1 came down the hall and asked her to come to Resident #2's room. Nurse #1 stated she entered the room and Resident #2 was on his back perpendicular to the bed and Resident #1 was lying on top of him. Nurse #1 stated Resident #2 was naked from the waist down and Resident #1's brief and pants were pulled down to her ankles and Resident #2 was attempting to penetrate Resident #1's vagina. Nurse #1 stated they assisted Resident #1 off of Resident #2 and removed her from the room. Nurse #1 stated Resident #1 was found in Resident #2's room again about 30 minutes later by Nurse Aide #2. Nurse #1 stated Resident #1 was put on one-to-one observation after the second time she was found in Resident #2's room. Nurse #1 stated Resident #1 was able to transfer herself to the toilet and could pull down her brief and pants and Resident #2 was independent for dressing and undressing.</p> <p>Attempts were made during the survey to reach</p>	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 7</p> <p>Nurse #2 who was assigned to Resident #1 and Resident #2 during the 7:00 am to 7:00 pm shift on 6/16/2024. Nurse #2 no longer worked for the facility and did not return messages left for a return call.</p> <p>On 6/25/2024 at 2:35 pm an attempt was made to interview Resident #2 and due to his cognition he was not able to answer any questions.</p> <p>Resident #1 was observed in her room on 6/26/2024 at 10:00 am and an attempt was made to interview her regarding the incident on 6/16/2024. Resident #1 did not remember the incident.</p> <p>During an interview on 6/25/2024 at 4:45 pm the Director of Health Services (DHS) was interviewed by phone and stated on Sunday, 6/16/2024 at 1:10 pm she received a call from Nurse #2 who reported the incident that occurred at 1:00 pm. The DHS stated Resident #1 was found approximately 30 minutes later in Resident #2's room, by Nurse Aide #2, and Resident #1 had her hand on the front of Resident #2's pants like she was trying to take his pants off. The DHS stated Resident #1 was not put on one-to-one observation until after she was found in Resident #2's room a second time. The DHS also stated both Resident #1 and Resident #2 were very confused, but neither of them had behaviors of inappropriate touching before the incident. She stated she tried to interview Resident #1 after the incident but she denied the incident happened.</p> <p>The Nurse Practitioner (NP) was interviewed on 6/25/2024 at 1:58 pm and she stated both Resident #1 and Resident #2 were cognitively impaired and did nto have the capacity to consent</p>	F 600			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 8 to sexual contact.</p> <p>During an interview with the Administrator on 6/25/2024 at 12:24 pm he stated he was aware of allegation of sexual touching between Resident #1 and Resident #2 that occurred on 6/16/2024 at approximately 1:00 pm. He stated he was not aware of the second incident between Resident #1 and Resident #2 and one-to-one observation should have been put into place after the first incident between the two residents.</p> <p>The Administrator was notified of immediate jeopardy on 6/26/2024 at 10:36 am.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.</p> <p>The facility failed to protect Resident #1's and Resident #2's right to be free of sexual abuse. Both Resident #1 and Resident #2 had severe cognitive impairment and were not capable of consenting to sexual acts.</p> <p>On 6/16/2024 at 1:00 PM Nurse Aide #1 entered Resident #2's room. Resident #2 (a male resident) was lying on his bed with Resident #1 (a female resident) lying on top of him. Resident #2 was undressed from the waist down and Resident #1's brief and pants were down around her ankles. According to the written statements of Nurse Aide #1 and Nurse Aide #2, Resident #1 was humping Resident #2 and Resident #2 had an erection and was trying to penetrate Resident #1 but was not able to. Nurse #1 stated Nurse</p>	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 9</p> <p>Aide #1 called out to her (she was in the hall), Nurse Aide #1 left the room to get her (Nurse #1) and she entered the room (approximately 5 minutes after she was notified) and observed Resident #1 lying on top of Resident #2 and Resident #2 had his hand on his penis which was erect and was trying to place his penis in Resident #1. Nurse #1 stated Resident #2 had not penetrated Resident #1. Nurse #1 stated she instructed Nurse Aide #1 and Nurse Aide #2 to Resident #1 off Resident #2, and they dressed her and wheeled her from the room. After removing Resident #1 from Resident #2's room, they wheeled her down the hallway for monitoring. According to the staff, monitoring Resident #1 was a collective effort.</p> <p>Approximately 30 minutes later, Resident #1 was again found in Resident #2's room with her hand on the front of Resident #2's pants and when asked what she was doing she stated she was fixing his pants. It was at this time a dedicated staff member was assigned one to one to Resident #1.</p> <p>On 6/19/2024, Resident #1's skin was assessed by a facility staff nurse to help ensure there was no skin impairment because of the incident. Resident #2's skin assessment was done by the charge nurse on 6/26/2024. The assessment revealed no skin impairments. Resident #1 had a room change on 6/25/2024 to remove her from proximity to Resident #2. On 6/16/2024 Resident #1 was placed on dedicated 1:1 monitoring until the psychiatrist deems her change in medication has stabilized her behaviors. On 6/20/2024 Resident #1 and Resident #2 were evaluated by their psychiatrist. Resident #1's medication, paroxetine, a psychotherapeutic medication, was</p>	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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	<p>Continued From page 10</p> <p>evaluated and increased. Resident #1's care plan and resident profile were reviewed and identified "touching other residents" and was reviewed and revised on 6/27/2024 to reflect the medication changes and 1:1 monitoring. On 6/27/2024, Resident #2 did not have required any changes to his medication regimen, Resident #2's care plan was reviewed and revised on 6/27/2024 to include sexual inappropriate behaviors towards others to include attempted sexual encounter with another resident.</p> <p>The Administrator directed the Nurse Managers and Licensed Nurses on 6/26/2024 to complete the skin observations of all residents with a Brief Interview for Mental Status (BIMS) of 9 or below to identify any skin impairments of unknown origin (bruises, skin tears). Residents with a BIMS score of 10 or above will be interviewed by a Department Manager (Administrator, Social Worker, Clinical Competency Coordinator, Case Mix Director, Director of Health Services, Nurse Navigator) on 6/27/2024 regarding any concerns related to abuse, nonconsensual sexual abuse, and mistreatment. The facility will initiate abuse prevention, identification and reporting policy if any concerns are identified from skin assessments and resident interviews. This includes notification to the State agencies, police and local adult protective services.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.</p> <p>On 6/26/2024, during an Ad Hoc Quality Assurance Meeting, the Administrator and Clinical Competency Coordinator educated the</p>	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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	<p>Continued From page 11</p> <p>Department Managers (Director of Health Services, Social Worker, Environmental Services, Dietary Manager, Case Mix Director, Cas Mix Coordinator, Financial Counselor, Nurse Navigator, Admissions Director) on the facility's Prevention of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation Policy and Procedures that includes "sexual abuse is non-consensual sexual contact of any type with a resident" and staff's heightened awareness of sexually inappropriate actions between residents. In the event of a resident-to-resident nonconsensual sexual behavior, the residents will be provided a one-to-one staff member until review is made by the provider (Nurse Practitioner, Physician, Psychiatrist) to determine a removal plan for the one-to-one. One-to-one is a dedicated staff member assigned to the resident to prevent further occurrences of a specific behavior. The Director of Health Services and/or Nurse Managers assign the designated staff members by identification on the Certified Nursing assignment sheet.</p> <p>On 6/26/2024 the Clinical Competency Coordinator and Department Managers began educating their respective department related to the facility Prevention of Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Policy and Procedures that includes "sexual abuse is non-consensual sexual contact of any type with a resident" and staff's heightened awareness of sexually inappropriate actions between residents. Any resident voicing desire to have a sexual relationship with another resident will be evaluated by the provider (physician) and/or social worker to ensure both residents have the cognitive compacity to make an informed decision. In the event of a</p>	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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	<p>Continued From page 12</p> <p>resident-to-resident nonconsensual sexual behavior, or an observed sexual act without the staff's prior knowledge of consent of both residents with BIMS score of 10 or greater with cognitive capacity to consent to the sexual act, the staff members report the behavior to the Licensed Nurse, who reports to the Nurse Manager and Administrator. The residents will be provided a one-to-one staff member until review is made by the provider (Nurse Practitioner, Physician, Psychiatrist) to determine the removal plan for the one-to-one. One-to-one is a dedicated staff member assigned to the resident to prevent further occurrences of specific behavior. Staff members not educated by 6/27/2024 will be educated prior to their next scheduled shift. The Administrator and/or Clinical Competency Coordinator are responsible for ensuring all staff are educated by 6/27/2024. Facility Staff who are scheduled to work will receive the in-person education; Facility Staff who are not scheduled to work will receive verbal education over the phone with review of education by their Department Manager and/or Administrator upon next scheduled shift. This education has been added to the general orientation for all newly hired staff provided by the Clinical Competency Coordinator. The Administrator and/or Clinical Competency Coordinator maintains the employee roster of those who have been educated and who require review.</p> <p>Alleged date of immediate jeopardy removal: 6/29/2024.</p> <p>Validation of the facility's Credible Allegation of Immediate Jeopardy removal was completed on 7/1/2024. Interviews were conducted with the</p>	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 Administrator, Director of Health Services, Nurse Aides, Nurses, Social Worker, Dietary Staff, Environmental Staff, Maintenance Director, Clinical Competency Coordinator, and Assistant Director of Nursing and staff were able to identify the different types of abuse, and that sexual abuse is non-consensual sexual contact of any type. Staff also indicated residents should be removed from abusive situations and monitored to ensure no further abuse occurs. The facility provided a skin assessment completed on 6/26/2024 for Resident #1 and she did not have any skin impairments. Resident #1's room was changed on 6/25/2024 to remove her from the immediate vicinity of Resident #2. Resident #1 was placed on one-to-one observations and was observed during the validation on one-to-one observation. A review of Resident #1's medical record revealed she was seen by the Nurse Practitioner on 6/17/2024 and was seen by Psychiatric Services on 6/20/2024 and her psychotherapeutic medication, paroxetine was evaluated and increased. Resident #1's Care Plan was reviewed and updated on 6/27/2024 to reflect she had one-to-one monitoring and a change to her psychotherapeutic medication. Resident #2's care plan was reviewed and verified to be updated on 6/27/24. The facility provided Skin Assessment forms for residents with a BIMS of 10 or lower and documentation of interviews with residents with a BIMS higher than 10 to show that all other residents were assessed for abuse that were completed on 6/28/2024. The facility also provided a copy of the minute notes for their 6/26/2024 Quality Assurance Meeting which indicated the Quality Assurance Team discussed the facility's progress with their credible allegation and plan of correction. The facility's Immediate Jeopardy's removal date of 6/29/2024	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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 was validated.	F 600			
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95,  §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.  §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.  §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act.  §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.  This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to implement their abuse policy by failing to immediately implement	F 607	Resident #1 was placed on 1:1 monitoring. An initial investigation report regarding this incident has been	7/19/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 15</p> <p>protective measures when Nurse Aide #1 and Nurse Aide #2 observed two residents with severe cognitive impairment (Resident #1 and Resident #2) engaged in sexual activity that they did not have the capacity to consent to and the staff did not immediately separate the residents to provide protection from further abuse. The residents remained engaged in the sexual act until Nurse #1 arrived at the room and instructed Nurse Aide #1 and Nurse Aide #2 to separate the residents. Approximately 30 minutes after the residents were separated, Nurse Aide #2 observed Resident #1 back in Resident #2's room with her hands on the front of his pants and she was "attempting to remove them." Additionally, the facility failed to implement their abuse policy for reporting and investigating the sexual abuse for 2 of 4 residents (Resident #1 and Resident #2) reviewed for allegations of abuse.</p> <p>Immediate Jeopardy began on 6/16/2024 when the facility failed to immediately implement protective measures when Resident #1 and Resident #2 were observed engaging in sexual activity that they did not have the cognitive capacity to consent to. Immediate Jeopardy was removed on 6/29/2024 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (no harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>The facility's Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property</p>	F 607	<p>submitted to NC Department of Health and Human Services Regulation department on 6/26/24. The incident has also been reported to the County Adult Protective Services and the local Police department on 6/26/24.</p> <p>All other residents have the potential to be affected by the deficient practice.</p> <p>The Facility Administrator conducted an audit of all other abuse allegations within the past six months to ensure interventions were immediately implemented to protect the residents and prevent further abuse, that the allegations were reported as required and were investigated thoroughly. Any identified discrepancies will be addressed according to the abuse protocol up to and including notification to Department of Health and Human Services, Adult protective services and local police department (6/27/24). No issues were noted during this audit.</p> <p>An Ad Hoc Quality Assessment and Performance Improvement meeting was held to discuss and review its policies on abuse identification and abuse prevention and reporting (6/26/24). Attendees included the Administrator, Director of Nursing Services, Social Services, Case Mix Nurse, Nurse Navigator, Business Office, and Admissions Director. The Committee concluded the policy and procedure had not been followed. The committee reviewed the facility's policy on Abuse Identification as well as Abuse Prevention to ensure understanding of</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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 607	<p>Continued From page 16</p> <p>policy, last revised on 1/11/2024, included the following: Sexual abuse is non-consensual 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 would ensure that precautions were taken to protect the health and safety of the resident during the course of and following the investigation. The Administrator or their designee should notify the state agency and other agencies in accordance with the regulations and state law. The initial report to the state agency should include the nature and extent of any injuries. The investigation report was to be submitted to per state requirements.</p> <p>Resident #1 was admitted to the facility on 3/15/2023 and her diagnoses included dementia with psychosis and a cognitive communication deficit.</p> <p>A quarterly Minimum Data Set assessment dated 6/5/2024 indicated Resident #1 was severely cognitively impaired.</p> <p>Resident #2 was admitted to the facility on 11/8/2023 and his diagnoses included a history of stroke and schizophrenia.</p> <p>A quarterly MDS assessment dated 6/5/2024 indicated Resident #2 was severely cognitively impaired.</p> <p>A Witness Statement dated 6/16/2024 at 1:30 pm</p>	F 607	<p>how to identify and address allegations of abuse.</p> <p>The Clinical Competency Coordinator completed education with facility Nurse Managers and Department Managers (Dietary, Housekeeping, and Environmental Services) on abuse identification and abuse prevention and reporting, to ensure they were prepared and able to disseminate information to their staff (6/28/2024). Department Managers (Dietary, Housekeeping, and Environmental Services) along with the Clinical Competency Coordinator educated their staff on Abuse Identification as well as Abuse Prevention to ensure understanding of how to identify and address allegations of abuse. Those who have not received education by 6/28/24 will be provided education prior to the beginning of their next scheduled shift.</p> <p>Systemically, in addition to the facility's general orientation discussion on abuse and neglect, an annual review of the facility Abuse Identification as well as Abuse Prevention Policy to ensure understanding of how to identify and address allegations of abuse (6/28/2024). This education has also been added and reviewed during general orientation for newly hired staff and reviewed.</p> <p>To monitor the performance of this systemic change, interviews will be conducted for residents with a BIM score of 10 or above and skin checks will be completed for residents with BIMS score</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74 MONROE, NC 28110</b>		
(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 607	<p>Continued From page 17</p> <p>completed by Nurse Aide #2 included the following information: She entered Resident #2's room and found Resident #2 lying on his back with his body perpendicular to the bed with his legs hanging over the side of the bed and Resident #1 was lying on top of Resident #2. Both residents were naked from the waist down and Resident #2 had one hand on his penis and was trying to put his penis in Resident #1, and he was touching her private parts with his other hand. Nurse Aide #2 called out to Nurse Aide #1 and Nurse Aide #1 called out to Nurse #1. When Nurse #1 arrived at the room they assisted Resident #1 off Resident #2, dressed her, and removed her from the room.</p> <p>During an interview by phone with Nurse Aide #2 on 6/26/2024 at 10:00 am she stated she was assigned to Resident #1 and Resident #2 on 6/16/2024 on the 7:00 am to 7:00 pm shift. She stated she found Resident #1 in Resident #2's room. Nurse Aide #2 stated Resident #2 was lying on his back on his bed with his legs perpendicular to his bed and his legs hanging over the side of the bed with Resident #1 lying on top of him. Nurse Aide #2 stated Resident #2 had an erection and he had one hand on his penis and was trying to penetrate Resident #1's vagina but was not successful. She stated she was just inside the doorway of Resident #2's room when she saw Resident #1 and Resident #2 and she called out to Nurse Aide #1 who came to the room. She indicated Nurse Aide #1 then called out to Nurse #1 to come to the room. Nurse Aide #2 stated Nurse Aide #1 left the room to get Nurse #1 and was only gone a few minutes before Nurse #1 came to the room. Nurse Aide #2 stated she did not separate the residents prior to getting assistance from Nurse Aide #1 and they</p>	F 607	<p>of 9 or below to identify any potential areas of abuse. These audits will be conducted for ten residents weekly for four weeks. Thereafter these audits will be conducted for eight residents monthly for three months. Thereafter these audits will be conducted for eight residents quarterly unless reviewed and revised by the Quality Assurance Performance Improvement Committee.</p> <p>Administrator to monitor all reportable incidents weekly for timely and complete submission to all regulatory agencies. The Director of Health Services will report the analysis of the resident interviews and skin observations to the facility Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is achieved then quarterly thereafter. The administrator will report the analysis of the reportable incidents to the facility Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is achieved, then quarterly thereafter.</p> <p>Corrective Action will be completed by 7/19/2024</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 18</p> <p>(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.</p> <p>A Witness Statement written on 6/16/2024 at 1:30 pm by Nurse Aide #1 revealed the following: Nurse Aide #2 called her to Resident #2's room and Resident #2 was lying on his bed and Resident #1 was lying on top of him. Resident #2 was naked from the waist down and Resident #1's brief and pants were down. Resident #1 was humping Resident #2 and Resident #2 was rubbing 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</p>	F 607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 19</p> <p>Nurse #1 and she came to the room.</p> <p>During an interview with Nurse Aide #1 on 6/25/2024 at 1:14 pm she stated she was called to Resident #2's room Nurse Aide #2 on 6/16/2024. She stated when she arrived at Resident #2's room he was lying on his back on the bed perpendicular to the bed with his legs hanging off the bed and Resident #1 was lying on top of him. Nurse Aide #1 stated Resident #2 was trying to put his penis in Resident #1, but he was not able to. She stated she called out to Nurse #1, but Nurse #1 did not hear her, so she walked up the hallway from the 500-hall to the 400-hall and got Nurse #1. She stated when they returned to the room Resident #1 was still on top of Resident #2 and Resident #2 had his penis in his hand and was still attempting to penetrate Resident #1. Nurse #1 instructed them to get Resident #1 off Resident #2 and get her removed from the room. Nurse Aide #1 stated she felt they were shocked and neither she nor Nurse Aide #2 thought about removing Resident #1 from the room before calling Nurse #1 to the room. Nurse Aide #1 stated approximately 30 to 45 minutes after the first incident, Resident #2 was found in Resident #1's room again with her hand on the front of his pants and she was messing with his zipper. Nurse Aide #1 stated after the second incident Resident #1 was put on one-to-one observation.</p> <p>An interview was conducted with Nurse #1 on 6/25/2024 at 12:49 pm and she stated she was not assigned to Resident #1 or Resident #2 on 6/16/2024. She stated she was called to Resident #2's room by Nurse Aide #1. She stated Nurse Aide #1 had called to her but she did not hear her and then Nurse Aide #1 came</p>	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 20</p> <p>down to 400-hall (Resident #2's room was on 500-hall) and told her she needed to come to Resident #2's room. Nurse #1 stated it was approximately 5 minutes from the time Nurse Aide #1 came to get her until she arrived at Resident #2's room. Nurse #1 stated she entered Resident #2's room and observed Resident #2 naked from the waist down on his bed, lying on his back, with his legs perpendicular to the bed and his legs hanging off the bed; and Resident #2 was naked from the waist down and Resident #1's brief and pants were down to her ankles. Nurse #1 stated Resident #1 was lying on top of Resident #2, and Resident #2 had his hand on his penis, and he was trying to penetrate Resident #1. Nurse #1 stated Resident #2 had an erection, but she did not observe him penetrate Resident #1's vagina. She stated she instructed Nurse Aide #1 and Nurse Aide #2 to get Resident #1 off Resident #2, they dressed her and removed her from the room. Nurse #1 stated she did not assess either Resident #1 or Resident #2 for any injuries. She stated approximately thirty minutes after they removed Resident #1 from Resident #2's room she was found again by Nurse Aide #2 in Resident #2's room with her hand on the front of Resident #2's pants. Nurse #1 stated Resident #1 was put on one-to-one observation after she was found in Resident #2's room the second time, but she did not remember what time the one-to-one observation began.</p> <p>Attempts were made during the survey to reach Nurse #2 who was assigned to Resident #1 and Resident #2 during the 7:00 am to 7:00 pm shift on 6/16/2024. Nurse #2 no longer worked for the facility and did not return messages left for a return call.</p>	F 607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 21</p> <p>There was no evidence in Resident #1 or Resident #2's record that they were immediately assessed and there was no evidence the facility reported the sexual abuse to the state agency, Adult Protective Services, and law enforcement.</p> <p>The Director of Health Services (DHS) was interviewed on 6/25/2024 at 4:45 pm and she stated she received a call from Nurse #2 at 1:10 pm on Sunday, 6/16/2024, and was told Resident #1 was found in Resident #2's room, Resident #1 was lying on top of Resident #2 in his bed, and both residents were unclothed from the waist down. She stated she immediately called the Administrator and reported Resident #1 and Resident #2 were attempting to have sex and told him she was on her way to the facility to get witness statements and would keep him updated. The DHS did not indicate the Administrator gave her any instructions regarding the investigation and monitoring. The DHS stated she interviewed Nurse Aide #1, Nurse Aide #2, and Resident #1. The DHS stated she was not aware Resident #1 and Resident #2 were not separated immediately and was not aware Resident #1 was not put on one-to-one observation immediately. The DHS also stated the staff should have separated them immediately and put Resident #1 on one-to-one observation immediately to protect both residents. The DHS stated approximately 30 minutes after the initial incident Nurse Aide #2 found Resident #1 in Resident #2's room again. She stated Nurse Aide #2 told her, "she [Resident #1] had her hands on the front of his [Resident #2] pants like she was trying to take them off." The DHS stated Resident #1 was put on one-to-one observation after the second incident. The DHS stated Resident #1 did not have a skin assessment after the incident, but she took her to</p>	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 22</p> <p>the bathroom between 6:00 pm and 8:00 pm that evening and she did not have any bleeding when wiped and she did not complain of pain or grimace when she was wiped. The DHS stated she did not do any interviews or assessments of any other residents to ensure no one else was sexually abused; she did not do education with the staff regarding the facility's sexual abuse policy, and she did not report the incident to the state agency, Adult Protective Services, or the authorities. The DHS stated the Administrator was responsible for reporting abuse to the state agency, Adult Protective Services, and the authorities and she did not know why it was not reported.</p> <p>The Administrator was interviewed on 6/26/2024 at 1:15 pm and he stated he should have reported the allegation of sexual abuse to the state agency, Adult Protective Services, and the local law enforcement authorities and he should have asked more questions of the staff when the incident was reported to him on 6/16/2024. The Administrator stated since both residents were severely confused and were not aware they were doing anything wrong, he had not considered the incident to be sexual abuse. He revealed he realized now he should have reported the incident since neither resident was able to consent to the sexual activity. The Administrator stated staff had not made him aware there was a second incident with Resident #1 returning to Resident #2's room or that they had not separated Resident #1 and Resident #2 immediately after the first incident. The Administrator stated he should have made sure Resident #1 and Resident #2 were separated immediately and one-to-one observation was put into place after the first incident when Resident #1 was found in Resident</p>	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 23</p> <p>#2's room the first time to ensure both residents were safe. He stated he should have also ensured there were no other residents that may have been involved by having the other residents interviewed and assessed for any signs of abuse and he should have ensured education was completed with all the staff regarding reporting, investigating, and protecting residents from sexual abuse.</p> <p>The Administrator was notified of immediate jeopardy on 6/26/2024 at 10:36 am.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.</p> <p>On 6/16/2024 at 1:00 pm Nurse Aide #1 entered Resident #2's room and identified Resident #1 and Resident #2, who both lacked capacity to consent in a sexual compromising position and did not immediately separate them. Nurse Aide #1 called out for help to Nurse #1 (Nurse #1 was down the hall), Nurse Aide #1 left the room to get Nurse #1. When Nurse #1 and Nurse Aide #1 entered the room, they observed Resident #1 lying on top of Resident #2 and Resident #2 had his hand on his penis which was erect and was trying to place his penis in Resident #1. Nurse #1 stated Resident #2 had not penetrated Resident #1. Nurse #1 stated she instructed Nurse Aide #1 and Nurse Aide #2 to assist Resident #1 off of Resident #2 and they dressed her and wheeled her from the room. After removing Resident #1 from Resident #2's room, they wheeled her down the hallway for monitoring. According to the staff,</p>	F 607			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 24</p> <p>monitoring Resident #1 was a collective effort.</p> <p>Approximately 30 minutes later, Resident #1 was again found in Resident #2's room with her hand on the front of Resident #2's pants and when asked what she was doing she stated she was fixing his pants. It was at this this time a dedicated staff member was assigned to Resident #1.</p> <p>The issues leading to the facility not implementing its abuse policy for reporting, protecting, and investigating the allegation of resident-to-resident sexual abuse was due to a lapse in education. The facility should have treated this incident as abuse and reported to local and state agencies as outlined in its policy. Resident #1 and Resident #2 do not have the capacity to make rational decisions as it relates to sexual intercourse; therefore, their inability to make this decision could have resulted in injury or harm. The decision to monitor Resident #1 by different staff members observation versus a dedicated assigned staff member was not appropriate as it did not protect Residents #1 and #2 from each other and other facility residents. To help ensure the immediate protection of residents to prevent further occurrences, Resident #1 was placed on 1:1 observation on 6/16/2024. Direct monitoring will remain in place until deemed safe by Resident #1's physician.</p> <p>As a result of the facility not implementing its abuse policy, local and state agencies were not notified, which compromised the protection of residents and thorough investigation of the event. The lack of reporting and following the facility policy compromises all residents and their protection against abuse.</p>	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 25</p> <p>An initial investigation report regarding this incident has been submitted to NC Department of Health and Human Services Regulation department on 6/26/24. The incident has also been reported to the County Adult Protective Services and the local Police department on 6/26/24.</p> <p>On 6/27/24 the Facility Administrator conducted an audit of all other abuse allegations within the past six months to ensure interventions were immediately implemented to protect the residents and prevent further abuse, that the allegations were reported as required and were investigated thoroughly. Any identified discrepancies will be addressed according to the abuse protocol up to and including notification to Department of Health and Human Services, Adult protective services and local police department.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.</p> <p>An Ad Hoc Quality Assessment and Performance Improvement meeting was held 6/26/24 to discuss and review its policies on abuse identification and abuse prevention and reporting. Attendees included the Administrator, Director of Nursing Services, Social Services, Case Mix Nurse, Nurse Navigator, Business Office, and Admissions Director. The Committee concluded the policy and procedure had not been followed.</p>	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	<p>Continued From page 26</p> <p>The committee reviewed the facility's policy on Abuse Identification as well as Abuse Prevention to ensure understanding of how to identify and address allegations of abuse.</p> <p>On 6/26/24 the Clinical Competency Coordinator educated facility Nurse Managers and Department Managers (Dietary, Housekeeping, and Environmental Services) on abuse identification and abuse prevention and reporting, to ensure they were prepared and able to disseminate information to their staff. Department Managers (Dietary, Housekeeping, and Environmental Services) educated their staff on Abuse Identification as well as Abuse Prevention to ensure understanding of how to identify and address allegations of abuse on 6/26/2024. The Clinical Competency Coordinator also began education to all Facility Staff members on 6/26/24 on the facility abuse identification and abuse prevention and reporting policies. Staff education included all clinical and non-clinical staff. Those who have not received education by 6/28/24 will be provided education prior to the beginning of their next scheduled shift. The Administrator and/or Clinical Competency Coordinator maintains the employee roster of those who have been educated and who requires education and ensure staff do not work until education has been completed. All new employees will be educated by the facility Clinical Competency Coordinator during the New Employee Orientation and will not be permitted to work on the units until this education has been completed.</p> <p>Alleged date of immediate jeopardy removal: 6/29/2024.</p>	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345566</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-UNION POINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3510 WEST HIGHWAY 74</b> <b>MONROE, NC 28110</b>		
(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 607	Continued From page 27 On 7/1/2024 the facility's credible allegation of immediate jeopardy removal was validated. The facility provided documentation of education provided by the facility regarding implementing their abuse policy which included providing a thorough investigation, protection of the resident involved and all other residents, assessment of the resident involved and assessment and interview of all other resident, and reporting of all allegations of abuse to the state agency, adult protective services, and local police authorities which was completed on 6/26/2024. The facility provided the documentation of the sexual abuse allegation report sent to the state agency, adult protective services, and the local police department. The facility provided documentation of the one-to-one observation by staff of Resident #1 and observations of Resident #1 on one-to-one observations were completed during the survey. The facility's Administrator conducted an audit of all other abuse allegations within the past six months to ensure interventions were immediately put into place to protect residents from further abuse on 6/27/2024. An Ad Hoc Quality Assessment and Performance Improvement meeting was held on 6/26/2024 and the minutes indicated the facility reviewed their policies on abuse identification and abuse prevention and reporting. Facility staff were interviewed and were able to verbalize understanding of identification of abuse and how to prevent and report abuse. All the facility staff were knowledgeable about the types of abuse, who they should report abuse to, how they should protect the residents, and that residents should be assessed immediately if abuse is suspected. The facility's immediate jeopardy removal date of 6/29/2024 was validated.	F 607			