STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Rockingham	804 South Long Drive Rockingham, NC 28379

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews with the Nurse Practitioner and staff, the facility transferred a resident (Resident #88) with left hip pain after a fall. Resident #88 was diagnosed with a fracture of the left hip. The facility also failed to assess and obtain treatment orders for a skin tear (Resident #9). This deficient practice affected 2 of 2 residents reviewed for professional standards (Resident #88 and Resident #9).The findings included: 1. Review of the hospital Discharge summary dated [DATE] revealed that Resident #88 presented to the emergency room (ER) with complaints of right knee and hip pain following a fall several days prior. She was diagnosed with a minimally displaced fracture of the lateral condyle of the right tibia (a partial crack in the bone to the outer portion of the upper leg bone near the knee joint). Orthopedics evaluated the fracture and recommended non-operative management with no weight bearing on the right leg and the use of a knee brace. Resident #88 was admitted to the facility on [DATE] with diagnoses that included a nondisplaced fracture of the lateral condyle of the right tibia, unspecified osteoarthritis and congestive heart failure (CHF). A baseline care plan created 1/21/26 included a problem area for risk for falls or fall related injury related to right tibia fracture, decreased mobility and potential medication side effects. The care plan also included a problem area for Activities of Daily Living (ADL) decline related to right tibia fracture, CHF and acute respiratory failure. A Social Services progress note dated 1/23/26 and timed 5:06 PM, read that Resident #88 was noted on the floor on the left side of the bed. The note indicated the Social Services Director and Nurse Aide (NA) #2 entered the room with Nurse #1. The note stated that Resident #88 was attempting to self-transfer from the left side of the bed into the wheelchair, which rolled when she got into a standing position attempting to pivot and fell on her buttocks. Resident #88 was non-weight bearing on the right leg with a brace present. When Resident #88 was asked if she was in pain she stated yes to her tailbone/right hip. The note indicated the nurse completed range of motion and assessed Resident #88. Resident #88 felt pain subsided, an attempt to transfer resident to the wheelchair was made, but upon lowering her down she verbalized 10 out of 10 level of pain. An interview occurred with the Social Services Director on 5/13/26 at 9:50 AM. She stated that she recalled walking past Resident #88's room in the later part of the day on 1/23/26 and observed Resident #88 sitting on the floor beside her bed. She explained that NA #2 and Nurse #1 entered the room at the same time she did. The Social Services Director stated Resident #88 was sitting on the floor, with complaints of pain in her left hip. She recalled Nurse #1 performed an assessment but Resident #88 was wanting to get in the wheelchair and kept repeating the pain wasn't that bad. She (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated NA #2 and Nurse #1 attempted to transfer Resident #88 to the wheelchair and when she was starting to sit down that's when she complained of increased pain in the left hip and they placed her in the bed. The Social Services Director recalled Resident #88's pain was on the side that did not have a brace in place. A second interview took place with the Social Services Director on 5/14/26 at 9:57 AM. She verified she was unsure if leg length difference was present after Resident #88's fall on 1/23/26 but she did complain of pain to her hip. She explained she saw Nurse #1 have Resident #88 move her arms around but couldn't recall what type of assessment was completed for her legs. The Social Services Director explained Resident #88 kept saying she wasn't hurt and wanted to get off the floor, so Nurse #1 and NA #2 stood her up to get to the wheelchair, Resident #88 had severe pain and was placed in bed. On 5/13/26 at 1:54 PM, an interview occurred with NA #2 who had worked with Resident #88 on 1/23/26 at the time of the fall. She recalled walking by Resident #88's room and heard someone say hey. She walked into the room and observed Resident #88 sitting on the floor by her bed. She recalled the bed was in the lowest position but couldn't recall the placement of Resident #88's legs, if an assessment was performed by Nurse #1 or if Resident #88 was transferred off the floor. An eINTERACT Situation, Background, Assessment, Recommendation (SBAR) form dated 1/23/26, timed 5:15 PM and completed by Nurse #1, read that Resident #88 had a fall with left hip pain and decreased range of motion made worse with movement or pressure. Resident #88 currently had a closed fracture to the right leg. The form indicated Nurse Practitioner (NP) #1 was made aware on 1/23/26 at 5:20 PM and ordered an x-ray of the left hip and pelvis. A post fall observation form dated 1/23/26, timed 5:46 PM and completed by Nurse #1, indicated Resident #88 experienced an unwitnessed fall in her room. Resident #88 stated she wanted to get out of bed and the wheelchair was beside the bed. She stated she stood and lost her balance landing on her left hip and tail bone. Resident #88 was observed seated on the floor with her legs extended by NA #2 and Social Services Director. There was no attempt made to request assistance from Resident #88 and Resident #88 had declined NA's offer 15 minutes prior to the event. Interventions provided were marked as comfort care and diagnostic x-ray ordered. A nursing progress note dated 1/23/26, timed 5:50 PM and written by Nurse #1, read that Resident #88 continued with complaints of pain and notable shortening of the left leg with foot turned out was observed. An order was obtained to transfer Resident #88 to the ER for further evaluation. Multiple attempts were made to contact Nurse #1 on 5/13/26 and 5/14/26 without success. Nurse #1 was on duty at the time of Resident #88's fall on 1/23/26. A review of the hospital records dated 1/23/26 to 2/1/26 indicated that Resident #88 presented to the ER with complaints of left hip pain as well as left lower leg shortened and rotated out following a fall. She was diagnosed with a closed fracture of the left hip and underwent surgical repair on 1/24/26. A phone interview occurred with NP #1 on 5/13/26 at 12:17 PM, who recalled being called and informed that Resident #88 had experienced a fall from the bed. She stated she was not informed of any pain or leg length difference, or she would have ordered Resident #88 to be transferred to the ER for further evaluation rather than remaining in the facility for x-rays. NP #1 added that if a resident had a fall with visible injuries or complaints of pain, she would have expected the staff to leave the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident in place, make them comfortable, speak with the provider and allow Emergency Medical Services (EMS) to move them off the floor, to prevent further damage in the event of an injury. The Director of Nursing (DON) was interviewed on 5/13/26 at 2:06 PM and stated she recalled being informed Resident #88 had experienced a fall and she walked down to the room but couldn't recall the exact time. The DON stated when she arrived at Resident #88's room she was lying in bed, which was noted to be low to the ground. She stated she could immediately see the difference in leg length and Resident #88 was complaining of pain in her hip. The DON explained that Nurse #1 told her that a provider had been notified and an order was obtained to complete an in the facility x-ray. The DON stated she told Nurse #1 to cancel that order as Resident #88 needed to be seen at the hospital. The DON stated she called the NP, explained what she observed and received an order for Resident #88 to be evaluated at the hospital. The DON was unable to state what type of assessment was performed by Nurse #1 at the time of the fall but would have expected Resident #88 to remain in place on the floor until EMS arrived, to prevent further damage, if there were complaints of pain or if any abnormalities had been observed. 2. Resident #9 was admitted to the facility on [DATE] with diagnoses that included orthopedic aftercare following surgical amputation. Resident #9's quarterly Minimum Data Set (MDS) dated [DATE] indicated his cognition was intact, and behaviors were not exhibited during the look-back period. Functional limitation in range of motion impairment on both sides of lower extremities. Resident #9 required substantial/maximal assistance to shower/bathe self and bed mobility. He was dependent on staff with toileting hygiene, dressing, personal hygiene, and transfers. Resident #9 had no pressure ulcers and was receiving the application of nonsurgical dressings (with or without topical medications), and applications of ointments/medications other than to feet. Resident #9's care plan, last revised on 05/08/26 did not include a focus area for skin tears to left arm/elbow. The care plan did include an area for skin tears to Resident #9's right lower extremity. The interventions included for staff to monitor for and report skin changes or deterioration in wound status to provider and to perform care to sites as ordered and as needed. An observation and interview were conducted on 05/11/26 at 9:35 AM with Resident #9. On observation of Resident #9, he had a clear rectangle dressing on top of white gauze to his left arm/elbow area. The white gauze had brown and red substance on around the edges and in the center of the gauze. The bandage had no date or any writing on it. Resident #9 stated he obtained the skin tear to his left arm, a few days ago, I think it was Friday (5/8/26). He explained that while a nursing assistant (NA) was changing his brief he turned him onto his side and he almost fell off the bed, the NA grabbed him to prevent him from falling and while doing that the NA caused the skin tear to his left arm. (He pointed at the undated dressing on his left forearm area). Resident #9 could not recall the NA's name. Resident #9's physician orders from 05/01/26 through 05/11/26 revealed no orders for skin tear treatment to Resident #9's left arm/elbow area. An order dated 05/12/26 read: apply antibiotic ointment to left elbow skin tear, cover with dressing if needed until healed. An observation and interview were conducted on 05/12/26 at 11:01 AM with Resident #9's Hospice Nurse. The Hospice Nurse stated she was unaware of a skin tear to Resident #9's left arm/elbow area and that there was not a bandage in place to the area on 05/07/26 when she last visited (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9. The Hospice Nurse removed the dressing, a bordered gauze that had a date of 05/11/26 with the Wound Nurse's initials on top of it. Under the removed dressing Resident #9 had two skin tears side by side with scant bleeding noted. An interview was conducted on 05/12/26 at 11:09 AM with the Wound Care Nurse. She stated a NA, (could not remember which NA), came to her on 05/11/26 in the late afternoon and advised her Resident #9 had a skin tear to his left elbow area. The Wound Care Nurse explained she had not been previously notified of the skin tear to Resident #9's left arm. She stated the area had 2 linear skin tears that had blood on them, she cleaned and bandaged the areas. The Wound Care Nurse explained that Resident #9 had told her he hit his arm on the underneath side of the bedside table and caused skin tears. She denied asking the nurse what had happened or notifying the nurse of the skin tear. An interview was conducted on 05/12/26 at 11:47 AM with NA #2. She verified she had worked with Resident #9 on 05/08/26 from 7:00 AM to 3:00 PM. She explained that Resident #9 did not have any skin tears on his left arm. NA #2 could not recall seeing a bandage on his left arm/elbow area on 05/12/26. A phone interview was conducted on 05/12/26 at 7:41 PM with NA #5. She verified she was Resident #9's direct care NA on 05/09/26 from 7:00 AM to 7:00 PM. She denied seeing a skin tear or a bandage to Resident #9's left arm. An interview was conducted on 05/12/26 at 12:14 PM with NA #1. He stated no events occurred during care with Resident #9 on 05/08/26 from 3:00 PM to 7:00 PM, 05/10/26 from 7:00 AM to 7:00 PM, or 05/11/26 from 7:00 AM to 3:00 PM. He explained that while he was providing incontinence care to Resident #9 on 05/08/26 Resident #9 told him he had almost fallen during care in the past and for NA #1 to not let him fall when he turned him onto his side. NA #1 went on to explain that at no time during providing care did Resident #9 fall or almost fall from the bed. NA #1 indicated he did not cause skin tears to Resident #9's left arm. A phone interview was conducted on 05/12/26 at 11:51 AM with Nurse #3. She verified she had worked with Resident #9 on 05/08/26, 05/09/26, or 05/10/26 from 7:00 PM to 7:00 AM. She explained she did see a bandage to Resident #9's left arm/elbow area over the weekend but could not recall what days. She explained she did not know why there was a bandage in place. No events occurred during her shift, no treatment order was scheduled for her shift, and she did not apply the bandage. An interview was conducted on 05/12/26 at 12:07 PM with NA #3. She had worked with Resident #9 on 05/10/26 from 7:00 AM to 7:00 PM and she was not aware of a skin tear to Resident #9's left arm/elbow area. She could not recall seeing a bandage on his left arm/elbow area. She then stated she could have over-looked the bandage. A phone interview was conducted on 05/12/26 at 12:51 PM with Nurse #2. She verified she was the direct care nurse for Resident #9 on 05/08/26 and 05/10/26 from 7:00 AM to 7:00 PM. She stated she did see a bandage to Resident #9's left arm/elbow area on 05/08/26 however she did not know why the bandage was in place nor did she check the treatment orders to see if he had a treatment order in place. A follow-up interview was conducted on 05/12/26 at 3:08 PM with the Wound Care Nurse. She stated she did not initiate a treatment order or complete an incident report for the skin tear on the evening of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/11/26 at approximately 6:45 PM because she was getting ready to leave the facility for the day and figured she would complete them on the morning of 05/12/26 upon returning to work. She indicated she did not think of asking the floor nurse to complete the treatment order or incident report. The Wound Care Nurse explained she added the treatment order and completed an incident report on 05/12/26. An interview was conducted on 05/12/26 at 3:22 PM with the Director of Nursing (DON) in the presence of Administrator and Corporate Nurse Consultant. The DON indicated she was unaware Resident #9 had a skin tear to his left arm/elbow area, unaware an incident report had not been completed, and unaware a treatment order was not completed at the time a bandage was applied to the skin tears to Resident #9's left arm. The DON stated the Wound Care Nurse completed the order and an incident report on the morning of 05/12/26. Her expectation was the nurse that finds or made aware of a new skin issue to initiate the treatment order, incident report, and make the Wound Care Nurse aware of the new area. Unsuccessful attempts were made during the survey period to contact NA #4 (Scheduled for C hall on 05/08/26 and 05/09/26 from 7:00 PM-7:00 AM) and Nurse #5 (Scheduled as the shift supervisor on 05/08/26 and 05/10/26 from 7:00 PM-7:00 AM). There was no answer to the call attempts and the mailbox was full.