STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305024	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Manor	40 Whitehall Road Rochester, NH 03867

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined that the facility failed to report an injury of unknown source to the State Survey Agency (SSA) for 1 of 1 residents reviewed for neglect. (Resident identifier is #1).Findings include:Review on 1/14/26 of Resident #1's progress note, dated 12/8/25 at 11:26 a.m., revealed a note by Staff D (Physician Assistant) that read, Chief complaint: Nursing request eval [evaluation] for LUE [Left Upper Extremity] swelling. New LUE edema exam. Most consistent with dependent edema in setting of severe hypoalbuminemia, as well as patient reported sleeping on left side. Though some of the swelling to LUE does not appear to be pitting, and there is minimal erythema/warmth and slight tenderness. Doubt cellulitis though there is some concern for LUE DVT [Deep Vein Thrombosis]. Will transfer emergently to hospital for Doppler study rule out LUE DVT.Review on 1/14/26 of Resident #1's hospital Patient Visit Information, dated 12/8/25 at 11:02 a.m., revealed, You were seen today for: Closed fracture of radial head. elbow fracture. There was no additional paperwork from the hospital for the emergency room visit in Resident #1's medical record.Interview on 1/14/26 at 1:25 p.m. with Staff E (Registered Nurse) revealed that on 12/8/25, prior to the resident returning to the facility from the Emergency Room, they received a phone call from the Hospital emergency room and a verbal report that Resident #1 had a fracture. Interview on 1/14/26 at 12:30 p.m. with Staff B (Director of Nursing) revealed that the facility did not send a report to the SSA for the above elbow fracture (injury of unknown origin).Review on 1/14/26 of the facility's policy titled Abuse Prohibition revised 11/14/25 revealed, . 6.4 Injuries of unknown source will be investigated to determine is abuse or neglect is suspected. 7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administer or designee will perform the following . 7.1 Enter allegation into the [omitted name of facility software system] Risk Management Portal . 7.3 Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source) . not less than two (2) hours after the allegation is made if the event results in serious bodily injury . 9. The Administrator or designee will . 9.2 Report finding of all completed investigations within five (5) working days to the Department of Health using the state on-line reporting system or state-approved forms .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, it was determined that the facility failed to thoroughly investigate an injury of unknown source for 1 of 1 resident reviewed for neglect. (Resident Identifier is #1). Findings include:Review on 1/14/26 of Resident #1's progress note, dated 12/8/25 at 11:26 a.m. revealed, a note by Staff D (Physician Assistant) that read, Chief complaint: Nursing request eval [evaluation] for LUE [Left Upper Extremity] swelling. New LUE edema exam. Most consistent with dependent edema in setting of severe hypoalbuminemia, as well as patient reported sleeping on left side. Though some of the swelling to LUE does not appear to be pitting, and there is minimal erythema/warmth and slight tenderness. Doubt cellulitis though there is some concern for LUE DVT [Deep Vein Thrombosis]. Will transfer emergently to hospital for Doppler study rule out LUE DVT.Review on 1/14/26 of Resident #1's hospital Patient Visit Information, dated 12/8/25 at 11:02 a.m., revealed, You were seen today for: Closed fracture of radial head. elbow fracture. Interview on 1/14/26 at 12:30 p.m. with Staff B (Director of Nursing) revealed that the facility did not do an investigation regarding the above elbow fracture.Review on 1/14/26 of the facility's policy titled Abuse Prohibition revised 11/14/25 revealed, . 6.4 Injuries of unknown source will be investigated to determine is abuse or neglect is suspected. 7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administer or designee will perform the following . 7.1 Enter allegation into the [omitted name of facility software system] Risk Management Portal . 7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on : 7.7.1 whether abuse or neglect occurred and to what extent; 7.7.2 clinical examination for signs of injuries, if indicated; 7.7.3 causative factors; and 7.7.4 interventions to prevent further injury. 7.8 The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnessed interviews is included .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, it was determined that the facility failed to provide notice to the resident or the resident representative(s) of transfer and bed hold for 1 of 2 residents reviewed for hospitalization (Resident identifier is #1).Findings include:Review on 1/14/26 of Resident #1's progress note dated 12/8/25 with an effective time of 11:26 a.m. revealed a note by Staff D (Physician Assistant) that read, Chief complaint: Nursing request eval [evaluation] for LUE [Left upper extremity] swelling. New LUE edema exam. Most consistent with dependent edema in setting of severe hypoalbuminemia, as well as patient reported sleeping on left side. Though some of the swelling to LUE does not appear to be pitting, and there is minimal erythema/warmth and slight tenderness. Doubt cellulitis though there is some concern for LUE DVT [deep vein thrombosis]. Will transfer emergently to hospital for Doppler study rule out LUE DVT.Review on 1/14/26 of Resident #1's hospital Patient Visit Information from the local hospital, dated 12/8/25 at 11:02 a.m., revealed, You were seen today for: Closed fracture of radial head. elbow fracture. Review on 1/14/26 of Resident #1's medical record revealed there was no Notice of Transfer/Discharge completed for the 12/8/25 transfer to the hospital.Interview on 1/14/26 at 2:00 p.m. with Staff B (Director of Nursing) confirmed the above findings. Review on 1/14/26 of the facility's policy Discharge and Transfer revised on 6/11/25 revealed, . 5. For patients transferred to a hospital: For unplanned, acute transfers, the patient must be permitted to return the Center. Prior to the transfer, the patient and patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific form. 5.4 A copy of the state specific or E-Interact form will be placed in the patient's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, it was determined that the facility failed to ensure that resident medical records were complete and accurately documented for 1 of 4 medical records reviewed. (Resident Identifier is #1.)Findings Include:Review on 1/14/26 of Resident #1's progress note, dated 12/8/25 at 11:26 a.m., revealed a note by Staff D (Physician Assistant) that read, Chief complaint: Nursing request eval [evaluation] for LUE [Left upper extremity] swelling. New LUE edema exam. Most consistent with dependent edema in setting of severe hypoalbuminemia, as well as patient reported sleeping on left side. Though some of the swelling to LUE does not appear to be pitting, and there is minimal erythema/warmth and slight tenderness. Doubt cellulitis though there is some concern for LUE DVT [deep vein thrombosis]. Will transfer emergently to hospital for Doppler study rule out LUE DVT.Review on 1/14/26 of Resident #1's hospital Patient Visit Information from the local hospital, dated 12/8/25 at 11:02 a.m., revealed, You were seen today for: Closed fracture of radial head. elbow fracture. Further review revealed follow-up care for Orthopedic Surgery and Family Medicine in 2 days, to keep the arm elevated to reduce pain/swelling and ice pack to the injured area. There was no additional paperwork from the hospital in the medical record.Review on 1/14/26 of Resident #1's nursing progress notes and nursing assessments for 12/8/25 and 12/9/25 revealed no documentation of when Resident #1 was transferred to the hospital or when they returned to the facility. Upon return to the facility there was no documentation that Resident #1's was assessed or that recommendations from the hospital were reviewed or implemented. Interview on 1/14/26 at 12:30 p.m. with Staff B (Director of Nursing) confirmed that there was no nursing documentation in Resident #1's medical record regarding when they went to the emergency room or when they returned on 12/8/25. Review on 1/14/26 of the facility's policy titled Nursing Documentation revised 5/1/23 revealed, . 2. Documentation included information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes, and responses to nursing care. 3. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures . 5. The patient's record specifies what nursing interventions were performed by whom, when, and where. 6. All patient information will be documented, scanned, or entered in the appropriate section of the clinical record following established guidelines .