

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Birch Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Rochester Hill 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, it was determined that the facility failed to document that the resident and/or the resident's representative was fully informed of the risk and benefits of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications in a final sample of 18 residents. (Resident identifier is #10.) Findings include: Review on 9/18/25 of Resident #10's diagnosis list revealed that he/she had diagnoses of Dementia, Depression and Cognitive communication deficit. Review on 9/18/25 of Resident #10's physician orders revealed Resident #10 was prescribed the following psychotropic medications: Trazodone HCL (hydrochloride) Oral tablet 100 MG (milligrams) Give 1 tablet by mouth at bedtime for insomnia, order date was 6/24/25 Risperidone Oral tablet 0.5 MG Give 1 tablet by mouth two times a day for Depression, order date was 6/25/25 Sertraline HCL Oral tablet 50 MG Give 1 tablet by mouth one time a day for Depression, order date was 6/25/25. Review on 9/18/25 of Resident #10's medical record revealed that there was no evidence Resident #10 was informed of the risk and benefits of the above medications prior to initiation of the medications. Interview on 9/18/25 at approximately 1:31 p.m. with Staff A (Clinical Resource Nurse) confirmed the above findings.		

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

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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 alleged violation of abuse no later than 24 hours to the State Survey Agency (SSA) for 1 of 2 residents reviewed for abuse in a final sample of 18 residents (Resident identifier is #67). Findings include: Interview on 9/16/25 at approximately 9:22 a.m. with Resident #67 revealed that he/she had an alleged verbal and physical altercation with Resident #68 on 9/14/25 after Bingo. Resident #68 grabbed Resident #67's upper arm. Resident #68 swore at Resident #67 and told them to die. Resident #67 said they reported the incident on 9/15/2025 to Staff F (Rehabilitation Director). Interview on 9/18/25 at 9:25 a.m. with Staff F revealed that Resident #67 informed them about the verbal and physical altercation. Staff F revealed that he/she notified Staff E (Social Service Director) and Staff G (Administrator). Interview on 9/18/25 at 9:35 a.m. with Staff G confirmed that they became aware of the resident to resident incident on 9/15/25. Staff G revealed that the allegation of abuse was not reported to the SSA. Interview on 9/18/25 at 9:58 a.m. with Staff H (Director of Nursing) revealed that the resident to resident incident was reported to her on 9/15/2025 and she had not spoken to both residents involved. Staff H confirmed that the allegation of abuse was not reported to the SSA. Review on 9/18/25 of the facility's policy titled, Reporting Alleged Violations, revision date of 8/01/21, revealed, .1. All alleged violations involving abuse, neglect, exploitation or mistreatment must be reported immediately. 2. If the alleged violation involves abuse it must be reported immediately but no later than 2 hours after the allegation is made. Definitions, Verbal Abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, it was determined that the facility failed to ensure that residents received scheduled medications on days that they attended dialysis for 1 of 1 resident reviewed for dialysis in a final sample of 28 residents (Resident Identifier is #6). Findings include: Interview on 9/16/25 at approximately 1:41 p.m. with Resident #6 revealed that he/she attended dialysis on Mondays, Wednesdays, and Fridays for a diagnosis of Stage 5 Kidney Disease. Interview on 9/17/25 at approximately 2:00 p.m. with Staff B (Medication Nursing Assistant) revealed that Doxazosin medication was not given on days of dialysis. Review on 9/18/25 of Resident #6's medication administration record (MAR) revealed an order for Doxazosin Mesylate tablet 1 MG, give 1 tablet by mouth in the afternoon for HTN [Hypertension], dated of 6/5/25. Resident #6's MAR revealed that his/her Doxazosin was not given on the following dates: 8/6/25, 8/8/25, 8/10/25, 8/13/25, 8/15/25, 8/18/25, 8/22/25, 8/25/25, 8/27/25, 9/1/25, 9/3/25, and 9/17/25. Interview on 9/18/25 at approximately 11:16 a.m. with Staff C (Unit Manager) confirmed the above findings and revealed there was no documentation that the provider was notified when the resident missed the above medications. Interview on 9/18/25 at approximately 11:24 a.m. with Staff I (Nurse Practitioner) revealed that Staff I was not aware that the Doxazosin was not given on dialysis days and that he/she was not notified.		