STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395751	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Residence and Care Center	174 Virginia Avenue Rochester, PA 15074

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 0554

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Allow residents to self-administer drugs if determined clinically appropriate.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46336

Based on review of facility policy, observations and staff interview, it was determined that the facility failed to determine it was safe to self-administer medications for one of five residents (Resident R1).

Findings include:

Review of the facility policy Resident Self-Administration of Medication dated 1/7/25, indicated a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE].

Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/2/25, indicated diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and high blood pressure. Section C0500 indicated a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. Resident R1's score was 8. The distribution falls into the 8-12 range meaning moderately impaired.

Review of Resident R1's current physician orders indicated the following medications to be administered in the morning: Diltiazem extend release capsule (treats heart arrythmias), Magnesium (supplement), Tylenol 2 tabs (pain medication), Apixaban (blood thinner), Seroquel (treats paranoid schizophrenia), and Tramadol (pain medication).

Observation on 2/25/25, at 10:05 a.m. indicated Resident R1 lying in bed with a cup of coffee on her overbed table. A medication cup with seven pills was also observed on the bedside table.

Interview on 2/25/25, at 10:06 a.m. Resident R1 indicated she takes her medications after she has her coffee.

Observation and Interview with Nurse Aide (NA) Employee E1 on 2/25/25, at 10:08 a.m. confirmed the medication cup was on overbed table and that there were seven pills inside.

(continued on next page)

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: 395751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Residence and Care Center	174 Virginia Avenue Rochester, PA 15074

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/25/25, at 10:10 a.m. Licensed Practical Nurse (LPN) Employee E2 indicated that Yes, Resident R1 likes to take her medications after her coffee. Review of Resident R1's clinical record on 2/25/25, at 11:00 a.m., failed to include a care plan, order for self-administration of medications, or an interdisciplinary assessment. Telephonic interview on 2/26/25, at 10:00 a.m. the Interim Director of Nursing confirmed Resident R1 did not have a current order, care plan to self-administer medications, or an interdisciplinary assessment, and that the facility failed to determine it was safe to self-administer medications for one of five residents (Resident R1). 28 Pa. Code 211.12(d)(1)(2)(3) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, and interview, the facility failed to have physician order specifications relating to size of indwelling catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) for one of five residents (Resident R4) and failed to provide privacy for the collection bags for three of five residents reviewed (Residents R4, R5, and R6). Findings include: Review of the facility policy Catheter Care dated 1/7/25, indicated it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Review of Admission record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/18/25, indicated diagnoses of neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), high blood pressure, and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Section H0100 indicated indwelling foley catheter use. Review of Resident R4's care plan dated 1/15/25, indicated to change foley catheter every month and as needed for suspected blockage or dislodgement. The care plan failed to include specifications of size for the catheter to be changed. Review of Resident R4's physician order dated 1/15/25, indicated catheter type: (specify) French (specify) neurogenic bladder every shift. The order failed to include the specifications required. Observation on 2/25/25, at 11:40 a.m. indicated Resident R4 in his room with a catheter collection bag full of urine clearly visible without a privacy bag. Interview on 2/25/25, at 11:45 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that Resident R4 did not have a privacy bag as required. Interview on 2/25/25, at 12:15 p.m. Interim Director of Nursing confirmed Resident R4's clinical record failed to provide specifications for size of the indwelling catheter as required. Review of Admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Section H0100 indicated indwelling foley catheter use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 174 Virginia Avenue Rochester, PA 15074	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R5's care plan dated 11/25/24, indicated resident demonstrates episodes of urinary incontinence (inability to control bladder). Encourage resident to communicate need to urinate. The care plan failed to indicate use of the indwelling urinary catheter, and/or care and management of it. Review of Resident R5's physician order dated 2/12/25, indicated Foley catheter 16 French (FR - circumference of the catheter) with 10cc (cubic centimeters) balloon. Observation on 2/25/25, at 10:14 a.m. indicated Resident R5 in bed with a catheter collection bag full of urine clearly visible without a privacy bag. Interview and observation on 2/25/25, at 10:16 a.m. Registered Nurse (RN) Employee E6 confirmed that Resident R5 did not have a privacy bag as required. Review of Admission record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of depression, stroke, and hemiplegia. Section H0100 indicated indwelling foley catheter use. Review of Resident R6's care plan dated 1/15/24, indicated Resident has an indwelling foley catheter for post operative bladder repair. Change foley catheter every month, and as needed for blockage or displacement. The care plan failed to provide specifications for size of the indwelling catheter as required. Review of Resident R6's physician order dated 1/14/25, indicated Foley catheter 16 FR with 10cc balloon. Observation on 2/25/25, at 11:35 a.m. indicated Resident R6 in bed with a catheter collection bag full of urine clearly visible without a privacy bag. Interview and observation on 2/25/25, at 11:40 a.m. Registered Nurse (RN) Employee E7 confirmed that Resident R6 did not have a privacy bag as required. Interview on 2/25/25, at 1:00 p.m. the Interim Director of Nursing confirmed the facility failed to have physician order specifications relating to size of indwelling catheter for one of five residents (Resident R4) and failed to provide privacy for the collection bags for three of five residents reviewed (Residents R4, R5, and R6). 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on observations, resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide medications within time guidelines for one of five residents reviewed (Resident R5). Findings Include: Review of the facility policy Nursing Services and Sufficient Staff dated 1/7/25, indicated it is the policy of the facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Review of Admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/25, indicated diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Observation on 2/25/25, at 10:14 a.m. Resident R5 was lying in bed, oxygen was not in nose as ordered, resident noted to have dried blood to left nostril, skin pale, and grunting while breathing. Observation and interview on 2/25/25, at 10:15 a.m. Registered Nurse (RN) Employee E6 arrived in room with Survey Agency (SA) and confirmed the resident had removed her oxygen and was with dried blood to the left nostril, skin pale, grunting while breathing. RN Employee E6 was unable to get oxygen saturation to register a reading after multiple attempts and replaced oxygen canula back in resident's nose. Review of Resident R5's physician ordered morning medications on 2/25/25, at 11:30 a.m. indicated the following medications were to be administered during the morning medication pass: Advair (inhaled medication to help breathing), Citalopram (antidepressant), Clonazepam (treats panic disorders, and anxiety disorders), Eliquis (blood thinner), Neurontin ((treats seizures, nerve pain, and neuropathy), Ipratropium-Albuterol (aerosolized medication to help breathing), Isosorbide (treats chest pain), Levetiracetam (treats seizures and brain hemorrhage), Claritin (treats allergies), and metoprolol (treats high blood pressure and chest pain). Interview on 2/25/25, at 11:50 a.m. Licensed Practical Nurse (LPN) Employee E2 was on the other side of the unit at a medication cart. When asked if Resident R5 had received her morning medications today, LPN responded I'm almost done this side. I'm going to that side next. When asked if she was the only nurse on the floor she indicated Yes. I can only go so fast to pass medications to 43 residents and verified the morning medications had not been administered within time guidelines as required. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/25/25, at 12:00 p.m. the [NAME] President of Operations Employee E8 indicated I wasn't aware she was the only nurse on the floor and confirmed the facility failed to have sufficient nursing staff to provide medications within time guidelines for one of five residents reviewed (Resident R5). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.19(7) Personnel policies and procedures. 28 Pa. Code 201.20(a) Staff development. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical record review, facility documents and staff interview it was determined the facility failed to ensure that residents were free from any significant medication errors for two of two residents (Residents R2 and R3). Findings include: Review of facility policy Medication Administration dated 1/7/25, indicated ensure the six rights of medication administration are followed: the right resident, the right drug, the right dosage, the right route, the right time, and the right documentation. Identify resident by photo in the Medication Administration Record (MAR). Compare medication source with the MAR to verify resident name, medication name, form, dose, route, and time. Review of the facility policy Medication Errors dated 1/7/25, indicated it is the policy of the facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Significant medication error is defined as one which causes the resident discomfort or jeopardizes his/her health and safety. Review of the admission record indicated R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/1/25, indicated diagnoses of hypertension (a condition in which the force of the flood against the artery walls is too high), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and depression (persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed). Review of Resident R2's progress note dated 12/17/24, at 4:00 p.m. indicated nurse self-identified incorrect medications given to resident. Review of facility provided documentation dated 12/17/24, indicated at approximately 4:00 p.m. Registered Nurse (RN) Employee E3 administered Metformin 500 milligrams (helps to control the amount of sugar in the blood - mg), Glipizide 5mg (helps to control the amount of sugar in the blood), Abilify 5mg (medication to treat mental disorders such as manic-depressive, major depression, or schizophrenia), Amlodipine 10 mg (medication to control blood pressure), and Gabapentin 300mg (treats seizures, nerve pain, and neuropathy), to Resident R2 in error. The medications were scheduled for Resident R2's roommate. Review of RN Employee E3's signed witness statement dated 12/17/24, indicated This RN confused resident from the work sheet, presuming it was the correct resident. This RN did not confirm with the resident; however, when RN finished administering the medications to Resident R2, RN realized that the medications were given to the wrong/incorrect resident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R2's physician orders dated 12/17/24, indicated to insert a peripheral intravenous (IV) catheter (a thin, flexible tube inserted into a vein the arm or hand to provide IV access for administration of fluids or medications). Start Dextrose-Sodium Chloride (provides electrolytes, calories, and is a source of water for hydration) 5 -0.45% (percent) at 70 mm/hr (millimeters/hour) for one day to equal one liter. Review of Resident R2's physician orders dated 12/18/24, extended the IV treatment to a total of two liters. Review of Nurse Practitioner (NP) Employee E4's progress note dated 12/18/24, indicated Reason for Acute Visit - inadvertent (not deliberate) administration of incorrect medications. Seen today for evaluation after mistakenly being given her roommates medications last night. Blood pressure and blood sugars are lower than baseline but remain stable. Continue to monitor closely. Diagnostic Statement - Poisoning by unspecified drugs, medicaments and biological substances, accidental, initial encounter. Continue IV infusion for a total of two liters. Continue to monitor vital signs and blood glucose every two hours. Review of the admission record indicated R3 was admitted to the facility on [DATE]. Review of Resident R3's dated 12/19/24, indicated diagnoses of hypertension, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and depression. Review of Resident R3's progress note dated 2/6/25, at 6:01 p.m. indicated Late Entry for 2/5/25, at 10:55 p.m. RN Employee E5 was asked to go to the third floor, as a nurse gave resident short acting insulin (medication that acts quickly, within two to four hours, to lower blood sugar levels) instead of her long acting insulin (insulin that does not have a peak time as it provides steady level of insulin throughout the day) in error. Blood sugar checked was 83 -85. Physician ordered resident to be sent to the emergency room for monitoring. Medic rescue services arrived and took Resident R3 to the emergency room at 10:55 p.m. Review of facility provided documentation dated 12/15/25, at 8:00 p.m. indicated RN Employee E3 administered 25 units of lispro insulin (a short acting, manmade version of human insulin), instead of 25 units of Lantus Pen (prefilled pen to inject long-acting insulin under the skin). Physician and 911 called for resident to be monitored and given IV fluids. Review of RN Employee E3's signed witness statement dated 2/6/25, indicated RN took bag with Lantus sticker on the outside and alcohol swab. Prepped pen with a needle and turned dial to 25 units as bag noted. RN did not check medication label on the actual pen and administered the 25 units of insulin. Upon returning the pen to the cart the RN realized the pen was a darker color and read label on pen which noted it was Lispro (short acting) pen. Review of Resident R3's physician order dated 2/5/24, indicated to send resident to the emergency room and initiate every one-hour checks of blood sugar. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 174 Virginia Avenue Rochester, PA 15074	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R3's emergency room report on 2/5/25, at 11:23 p.m. indicated chief complaint of medication error. Resident resides at local nursing center; she typically takes 25 units of Lantus each evening. Today 25 units of Lispro were inadvertently administered subcutaneously (under the skin) instead of the Lantus. This occurred at 9:10 p.m. Interview on 2/25/25, at 2:00 p.m. the [NAME] President of Operations Employee E8 confirmed the facility failed to ensure that residents were free from any significant medication errors for two of two residents (Residents R2 and R3). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.19(7) Personnel policies and procedures. 28 Pa. Code 201.20(a) Staff development. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions for three of five residents reviewed (Residents R5, R6, and R7). Findings include: Review of the facility policy Enhanced Barrier Precautions dated 1/7/25, indicated enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. A physician order will be obtained for residents with any of the following: wounds, indwelling medical devices (i.e. central lines and urinary catheters). Review of Admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/25, indicated diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body). Section H0100 indicated indwelling foley catheter use. Review of Resident R5's care plan dated 11/25/24, failed to indicate EBP requirements in relation to the indwelling urinary catheter. Review of Resident R5's physician orders dated 2/15/25, indicated Foley catheter 16 French (FR - circumference of the catheter) with 10cc (cubic centimeters) balloon. The care plan failed to indicate EBT related to foley catheter as required. Observation on 2/25/25, at 10:14 a.m. indicated Resident R5 in bed with a foley catheter. Observation of the door failed to have signage indicating EBP. Interview and observation on 2/25/25, at 10:16 a.m. Registered Nurse (RN) Employee E6 confirmed that Resident R5 did not have signage for EBP. Review of Admission record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of depression, stroke, and hemiplegia. Section H0100 indicated indwelling foley catheter use. Review of Resident R6's care plan dated 1/15/25, indicated resident requires EBP related to indwelling foley catheter. Review of Resident R6's physician order dated 1/15/25, indicated Foley catheter 16 French FR with 10cc balloon. EBT related to foley catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 2/25/25, at 11:35 a.m. indicated Resident R6 in bed with a foley catheter. Observation of the door failed to have signage indicating EBP. Review of Admission record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS dated [DATE], indicated diagnoses of enlarged prostate, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness). Section H0100 indicated indwelling foley catheter use. Review of Resident R7's care plan dated 2/4/25, failed to include EBP in relation to the foley catheter as required. Review of Resident R7's physician orders dated 2/4/25, failed to include an order for EBP in relation to the foley catheter. Observation on 2/25/25, at 11:30 a.m. indicated Resident R7 in bed with a foley catheter. Observation of the door failed to have signage indicating EBP. Interview on 2/25/25, at 11:40 a.m. Registered Nurse (RN) Employee E7 confirmed Resident R7 did not have signage indicating EBP. Interview on 2/25/25, at 2:00 p.m. the Interim Director of Nursing confirmed the facility failed to follow enhanced barrier precautions for three of five residents reviewed (Residents R5, R6, and R7). 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. 28 Pa. Code: 201.14 (a) Responsibility of licensee.