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	01/31/2026

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** Based on review of facility policy, review of clinical records, observations and staff interviews, it was determined that the facility failed to determine whether it was safe to self-administer medications for one of four residents (Resident R1).Findings include:Review of the facility policy Resident Self-Administration of Medications dated 12/11/25, indicated the facility to support each resident's right to self-administer medication. 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 indicated 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 11/3/25, indicated the diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and dementia (a group of symptoms that affect memory, thinking and interferes with daily life). Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aids in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was a 10 indicating Resident R1 was moderately impaired.During an observation on 1/31/26, at 11:05 a.m. Resident R1 was lying in bed. On the bedside table included a clear medication cup with four pills inside. Medication included: one white pill, one brown pill, one peach pill, and one black pill. No nurse was observed in the room at this time.During an interview on 1/31/26, at 11:07 a.m. Registered Nurse (RN) Employee E4 stated, It was a terrible oversight. I should have stayed in the room.During an interview on 1/31/26, at 11:08 a.m. RN Employee E4 confirmed the medication cup of pills sitting on Resident R1's bedside table.Review of Resident R1's physician orders failed to include an order for self-administration of medications.Review of Resident R1's care plan failed to address self-administration of medications.During a review of Resident R1's clinical record on 1/31/26, at 11:33 a.m. failed to reveal that a self-administration of medication assessment was completed.During an interview on 1/31/26, at 1:15 p.m. the Director of Nursing confirmed the facility failed to determine whether it was safe to self-administer medications for one of four residents (Resident R1).28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code: 211.12(d)(1)(5) Nursing services

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 01/31/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to maintain the confidentiality of residents' medical information on three of four medication carts (Vineyard, Rosewood, and Rosewood 2). Findings include:Review of facility policy HIPAA Security Measures dated 12/11/25, indicated it's the facilities policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and records that are in electronic format.During an observation on 1/29/26, at 10:45 a.m. the Vineyard Medication Cart and the Rosewood Medication Cart were observed sitting in the hallway, beside each other, and was left unattended with the computer screen open with identifiable information and any passerby could see resident personal and confidential information. During an interview on 1/29/26, at 10:47 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the Vineyard Medication Cart computer screen was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information.During an interview on 1/29/26, at 10:49 a.m. Registered Nurse (RN) Employee E2 confirmed the Rosewood Medication Cart computer screen was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information.During an observation on 1/31/26, at 10:31 a.m. the Rosewood 2 Medication Cart was observed sitting in the hallway and was left unattended with the computer screen open with identifiable information and any passerby could see resident personal and confidential information.During an interview on 1/31/26, at 10:33 a.m. RN Employee E3 stated, I was in a room, and confirmed that the Rosewood 2 Medication Cart was left unattended with the computer screen open with identifiable information and any passerby could see resident personal and confidential information.During an interview on 1/31/26, at 12:04 p.m. Nursing Home Administrator confirmed that the facility failed to maintain the confidentiality of residents' medical information on three of four medication carts (Vineyard, Rosewood, and Rosewood 2), as required.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.29(c.3) Resident Rights.28 Pa. code: 211.5(b)(1)(2) Medical records.28 Pa. Code: 211.12(d)(1)(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 01/31/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, resident interviews, and staff interview, it was determined that the facility failed to ensure comfortable air temperature levels (between 71-81 degrees Fahrenheit) were provided in the facility, and failed to monitor and assess all residents for hypothermia (a life-threatening medical emergency when the body loses heat faster than it can produce it), which created an Immediate Jeopardy situation, for 82 of 82 residents. Findings Include:Review of the facility policy Safe and Homelike Environment dated 12/11/25, indicated the facility will provide a safe, clean, comfortable, and homelike environment. This includes ensuring that the residents can receive care and services safely. Comfortable and safe temperature levels mean that temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia and is comfortable for the residents.Review of the facility policy Loss of Heating or Cooling dated 12/11/25, indicated the facility will take immediate actions when the facility's heating or cooling systems are inoperable in order to maintain temperatures within the facility at 71 -81 degrees Fahrenheit. The facilities include the following:Monitor temperatures in the facility.Increase frequent rounding to assess residents for changes in condition related to heat/cold.Layer clothing.Provide extra blankets.Serve warm foods and liquids.Monitor residents for signs of hypothermia. Notify physician as needed.During an interview on 1/28/26, at 3:30 p.m. Nursing Home Administrator (NHA) stated that she was made aware that the heat wasn't working last week. Then on Saturday 1/24/26, a heating company came in to fix a problem and after that fix facility was made aware that another part is needed. NHA presented audits of 5-6 random rooms on each floor but did not check all resident rooms nor did NHA have staff assess or interview residents to ensure their needs were being met.During an interview on 1/28/26, 5:30 p.m. Maintenance Employee E5 indicated that the heating system is not working at its full capability and that the heating company is returning to make the repairs needed. During observations on 1/28/26, 5:35 p.m. through 6:10 p.m. with Maintenance Employee E5 for rooms on the 3rd and 4th floor nursing units revealed that some residents say they were cold and some stating they were comfortable. Temperatures ranged from 68 degrees to 81 degrees. Observed resident windows were not fully closed and some residents stated that they opened the window. Residents did have extra blankets and clothing. All residents interviewed did state that no staff member offered any extra blankets or warm fluids to drink. During an interview on 1/28/26, at 6:08 p.m. Nursing Home Administrator confirmed that the heat is not working as it should and heating company will be returning to make repairs. NHA was made aware of the environmental concerns with the windows not being fully closed, the need to assess and ensure residents' needs are being met. Also, the need to conduct temperatures audits of the entire facility.During an interview on 1/29/26, at 9:05 a.m. NHA stated, The heaters are working but not 100%. That's why we are trying to get it fixed. We noticed it in the middle of last week. We called a company and they came on 1/24/26 and installed a control board. He then realized that the gas valve needed replaced. I approved the quote on 1/27/26, and he is here today fixing it. We are doing whole house temperature checks every shift, and started to audit blankets, offering hot chocolate, and to check windows to ensure they are closed.During a review of facility provided documentation, labeled Room Temp Audits, on 1/29/26, at 9:30 a.m. revealed that temperatures were obtained and recorded as the follow:At 2:00 a.m. the Third-Floor temperatures included 29 of 31 resident rooms were below 71 degrees Fahrenheit. The lowest temperature recorded was 63 degrees Fahrenheit.At 2:45 a.m. the Fourth-Floor temperatures included 30 of 31 resident rooms were below 71 degrees Fahrenheit. The lowest temperature (continued on next page)

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 01/31/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	recorded was 58.6 degrees Fahrenheit.During a tour of the facility on 1/29/26, from 10:30 a.m. - 11:15 a.m. the facility temperature felt cold throughout the Third, and Fourth floors.Observations conducted on 1/29/26, from 10:15 a.m. to 10:55 a.m. with Maintenance Employee E5 revealed the following air temperatures:Third floor Nursing Floor-room [ROOM NUMBER] -69.8 degrees Fahrenheit-room [ROOM NUMBER] -69.6 degrees Fahrenheit-room [ROOM NUMBER] -70.2 degrees Fahrenheit-room [ROOM NUMBER] -69.2 degrees Fahrenheit-room [ROOM NUMBER] -69.0 degrees Fahrenheit-room [ROOM NUMBER]- 67.8 degrees Fahrenheit-room [ROOM NUMBER]- 70.8 degrees Fahrenheit-room [ROOM NUMBER]- 68.4 degrees Fahrenheit-room [ROOM NUMBER]- 68.2 degrees Fahrenheit-room [ROOM NUMBER]- 68.2 degrees Fahrenheit-room [ROOM NUMBER]- 67.2 degrees Fahrenheit-room [ROOM NUMBER]- 68.6 degrees Fahrenheit-room [ROOM NUMBER]- 70.2 degrees FahrenheitDuring an observation on 1/29/26, at 10:18 a.m. Resident R2 was lying in bed with four blankets on covering her body.During an interview on 1/29/26, at 10:20 a.m. Resident R2 stated, My legs are cold, they gave me extra blankets. My window was cracked open last night.Observations conducted on 1/29/26, from 11:00 a.m. to 11:15 a.m. with Maintenance Employee E5 revealed the following air temperatures:Fourth floor Nursing Floor-room [ROOM NUMBER]-67.4 degrees Fahrenheit-room [ROOM NUMBER]-69.0 degrees Fahrenheit-room [ROOM NUMBER]-68.0 degrees Fahrenheit-room [ROOM NUMBER]- 66.2 degrees Fahrenheit-room [ROOM NUMBER]- 67.0 degrees FahrenheitDuring an interview on 1/29/26, at 11:24 a.m. Licensed Practical Nurse E6 stated, Residents complain that they are cold. I have brought in two bags full of blankets to pass out to keep them warm.During an observation on 1/29/26, at 11:29 a.m. Resident R1 was lying in bed, wearing a housecoat and had four blankets on covering his body.During an interview on 1/29/26, at 11:30 a.m. Resident R1 stated, I've been cold. I have all these blankets on. It gets real cold at night.During an observation on 1/29/26, at 11:32 a.m. Resident R8 was lying in bed, wearing a tassel cap and had three blankets covering her body.During an interview on 1/29/26, at 11:34 a.m. Resident R8 stated, This room is cold. When I get up, I get real cold.During an observation on 1/29/26, at 11:36 a.m. Resident R4 was lying in bed resting his eyes with four blankets on and personal winter coat laying over his legs.During an observation on 1/29/26, at 11:37 a.m. Resident R5 was lying in bed with four blankets covering her body.During an interview on 1/29/26, at 11:38 a.m. Resident R5 stated, I have been cold. I have all these blankets so I'm warm now.During an observation on 1/29/26, at 11:39 a.m. Resident R6 was lying in bed with blankets covering her body.During an interview on 1/29/26, at 11:40 a.m. Resident R6 stated, It is cold. I went to a meeting yesterday and it was really cold.During a tour and observation of the Third and Fourth Nursing Floors revealed only a few residents in the hallway or sitting at the nurse's station, with blankets covering them.During an interview on 1/29/26, at 12:21 p.m. the Heating Repairman stated, They called us last week and we came Saturday to look at it. There is two stages of heating. The first stage is working; the second stage is not working. We got the control board and installed it but then noticed the gas valve was needed. I just installed it and it is working now.Review of the clinical record indicated 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 11/3/25, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).During a review of Resident R1's clinical record on 1/29/26, at 12:47 p.m. failed to reveal any physician orders to monitor for hypothermia and to monitor resident temperatures. Last documented temperature was dated 1/6/26.Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].Review of Resident R7's MDS dated [DATE], indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), high blood pressure, and cerebral infarction (necrotic tissue in the brain resulting (continued on next page)

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 01/31/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	loss of blood and oxygen to the brain).During a review of Resident R7's clinical record on 1/29/26, at 12:48 p.m. failed to reveal any physician orders to monitor for hypothermia and to monitor resident temperatures. Last documented temperature was dated 1/25/26.Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE].Review of Resident R8's MDS dated [DATE], indicated diagnosis of dementia, depression, and high blood pressure.During a review of Resident R8's clinical record on 1/29/26, at 12:450 p.m. failed to reveal any physician orders to monitor for hypothermia and to monitor resident temperatures. Last documented temperature was dated 12/2/25.On 1/29/26, at 2:30 p.m. the NHA was notified that Immediate Jeopardy was called due the facility failed to maintain a temperature range between 71-81 degrees Fahrenheit and failed to monitor and assess all residents for hypothermia. The NHA was provided with the Immediate Jeopardy template, and a corrective action plan was requested.On 1/29/26, at 6:15 p.m.an immediate action plan was received and accepted which included the following interventions:Environmental Stabilization and Monitoring - The heating system repair has been completed as of approximately 12:15 p.m. on 1/29/26. Maintenance continues ongoing monitoring of system performance. Room temperature audits will be conducted in every resident room, every two hours until all resident rooms are at 71 degrees Fahrenheit or higher, then once every four hours by the Director of Nursing (DON) or designee daily for seven days, weekly for three weeks, then monthly for three months to ensure sustained compliance. Audits will include ensuring windows are closed and residents are offered plastic covering for windows, which will be completed by 7:00 p.m. on 1/29/26.Resident Monitoring and Hypothermia Evaluation, Resident Evaluation - All residents have been evaluated for signs and symptoms of hypothermia, including residents unable to independently express needs and residents who had a temperature taken over the last three days, and/or during whole house audit, of 97.6 degrees Fahrenheit or lower with no issues noted. This was completed by DON or designee by 4:00 p.m. on 1/29/26, with no issues noted. Any identified concerns in ongoing audits will be addressed immediately with individualized interventions, and orders are being placed for ongoing monitoring. Temperatures will be documented in weights/vitals section of electronic medical record and evaluation will be documented in progress notes.Resident Monitoring - Nursing staff or designee has conducted an audit of resident observations for cold intolerance, distress, or changes in condition related to temperature by 5:00 p.m. on 1/29/26. Interviewable residents are asked about comfort level and offered interventions as needed. Non-Interviewable residents are evaluated for observable signs of discomfort related to temperature. Resident monitoring audits will be conducted in every resident room, every shift by DON or designee daily for seven days, weekly for three weeks, then monthly for three months.Staff Education. Hypothermia Education - Nursing staff, including agency staff, will be educated on signs and symptoms of hypothermia, risk factors, interventions to prevent hypothermia, comfort measures to provide to residents, and appropriate response when signs or symptoms are identified. Nursing Assistants were educated on non-clinical signs and symptoms of hypothermia and to alert a nurse if observed. Education will be completed by the DON or designee and will be reinforced as needed. Education will be completed by 1/30/26, at 8:00 a.m. Staff educated by phone or email will sign the education prior to next working shift.Mitigation and Contingency Planning - Additional blankets, layering, and environmental adjustments are provided as needed. Residents offered room relocation as appropriate to maintain comfort. The facility has a plan to utilize outside resources, if necessary, to maintain safe air temperatures during future weather events or mechanical issues with updated rental company in place by 11:30 a.m. on 1/29/26.Policy and Procedure Review - Facility leadership has reviewed relevant policies and procedures related to environmental safety, resident monitoring, and emergency response. This was completed by 4:30 p.m. on 1/29/26. (continued on next page)

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 01/31/2026

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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Policies will be updated as indicated based on audit findings and Quality Assurance Performance Improvement (QAPI) review.QAPI Oversight - Audit findings, trends, and corrective actions are reported to the QAPI committee. The QAPI committee will evaluate effectiveness and recommend changes as needed.On 1/30/26, an Addendum was added, by the NHA, to the approved plan of correction to include the following:During review of audits and QAPI process, the facility leadership determined additional steps would be taken to continue to improve the facility temperature.After window audit, it was determined that every resident room and hallway windows in resident care areas would all receive plastic coverings to prevent drafts.After identifying that some knobs on registers were turned off, instead of on, leadership determined that clarification was needed to prevent others from inadvertently turning the heat off. This was completed by 11:00 p.m. on 1/29/26.Heating vendor who completed work on 1/29/26, is sending a tech back in to ensure correct functionality and to further explore the system to ensure no further corrections are needed. If any are needed, vendor will fix as soon as possible pending any parts or additional resources necessary.Six rental One ton heating units were installed by 2:00 a.m. on 1/30/26. These are being rented for the week at a minimum. On 1/31/26, a second Addendum was added, by the NHA, to the approved plan of correction to include the following:During review of audits and QAPI process, the facility leadership determined additional steps would be taken to continue to improve the facility temperature.On 1/30/26, the facility ordered two additional rental heating units and they were installed by 3:45 p.m.On 1/31/26, for facility resident rooms at 11:30 a.m. room temperature audits included five resident rooms that were showing under 71 degrees Fahrenheit with the laser thermometer gun. For those rooms, we re-temped using a room air thermometer, and all showed above 71 degrees Fahrenheit.Facility ordered air thermometers for each room which are due to be delivered on 1/31/26.During an interview on 1/30/26, at 9:00 a.m. NHA stated, We decided to put plastic on all the windows. We are still doing every two-hour room temperature check. At night we're having trouble keeping up the temperatures, but they are getting better. We got six portable heaters late last night. There are three on each floor.On 1/30/26, all resident orders were reviewed and verified to include monitoring for signs and symptoms of hypothermia and resident temperature checks.On 1/30/26, all residents progress notes were reviewed and verified to include a current temperature and an assessment for hypothermia.On 1/30/26, all residents were assessed and skin evaluations were completed and documented in residents' medical records. No negative outcomes were identified.On 1/30/26, temperature audits were reviewed. The facility is completing every two hours of temperature audits until all rooms are within normal range.On 1/30/26, QAPI meeting was held and signatures provided that attended meeting.On 1/31/26, current nursing staff, including agency, educated on signs and symptoms of hypothermia, identifying and reporting concerns to the physician, interventions used to prevent hypothermia, and how to prevent hypothermia. Staff will sign the education prior to their next working shift if education isn't completed in person.Staff education was verified with dated sign-in sheets and review of all current staff and agency staff utilized in the facility having signed and/or educated over the phone as indicated.During in-person verification completed on 1/31/26, from 10:00 a.m. until 12:00 p.m. 13 nursing staff confirmed that they were educated in person. Staff were educated on the definition of hypothermia, signs and symptoms to look for, when to report to physician, applying extra blankets, room changes, providing hot food and drinks, and to monitor residents more frequently.All staff educated in person signed the education sheet. All nursing staff members were educated. All other staff will be educated prior to their next shift and sign the education sheet.During an interview on 1/31/26, at 10:42p.m. Registered Nurse (RN) Employee E3 stated, I was educated on hypothermia. Monitor for signs and symptoms. Interventions like hot beverages and warm (continued on next page)

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 01/31/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	clothes. Watch for shivering, swelling, decrease responsiveness, decrease temperatures. Try to warm up but not too quickly.During an interview on 1/31/26, at 10:53 a.m. Nurse Aide (NA) Employee E8 stated, Residents are now requesting to take blankets off. If they were cold, I would offer them blankets. They may be confused. Give them warm drinks. Report low temperatures of residents to the nurse. I thought the education was helpful. It's a nice reminder.During an interview on 1/31/26, at 11:20 a.m. Nurse Aide (NA) Employee E7 stated, I was educated on hypothermia and temps of rooms. I would check temperatures, bundle residents up with blankets, and wear extra clothing. Keep them hydrated. I think the education was good. Helpful.During an interview on 1/31/26, at 11:32 a.m. Nurse Aide (NA) Employee E9 stated, They went over signs and symptoms of hypothermia. Watch for them complaining of cold, puffy faces, loss of consciousness, low temperatures. I learned to observe signs and symptoms of hypothermia. I thought the education was good and informative.During an interview on 1/31/26, Resident R2 stated, I feel a difference in the temperatures. It's warmer. They put plastic on the windows.During an interview on 1/31/26, Resident R9 stated, I'm warm. A few days ago, it was cooler but its warmer now.During an interview on 1/31/26, Resident R1 stated, Its warmer now. They put plastic up at the windows. I only need one blanket now.During an interview on 1/31/26, Resident R10 stated, Its much nicer than the other day. I don't need to use the blankets as much.Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 1/31/26, at 1:15 p.m. NHA was made aware.During an interview on 1/29/26, at 2:30 p.m. the NHA confirmed that the facility failed to ensure comfortable air temperature levels (between 71-81 degrees Fahrenheit) were provided in the facility, and failed to monitor and assess all residents for hypothermia (a life-threatening medical emergency when the body loses heat faster than it can produce it), which created an Immediate Jeopardy situation, for 82 of 82 residents. This failure created an immediate jeopardy situation by potentially putting residents at risk of harm or injury.28 Pa. Code: 201.18(b)(3) Management

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 01/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy, observations, and staff interviews, the facility failed to ensure the outside environment was free of potential accidental hazards, failed to evaluate the snow hazard, and failed to implement a plan for snow removal for two of two parking lot areas, walkways and surrounding grounds three days after a snowstorm (Front Parking and Rear Parking Area).Findings include:During an observation on 1/28/26, at 3:00 p.m. when the State Agency (SA) arrived at the facility, the front parking lot used to maintain a flow of vehicles for visitors, transport, and ambulances was impassable. Only one entrance way was plowed, which would cause emergency vehicles to have a difficult time turning around and exit the parking lot in case of an emergency. The exit to leave the parking lot was not plowed and snow was impeding the ability to leave quickly. Additionally, sidewalks leading to the building were not shoveled. The second parking area was covered with snow and not plowed, and vehicles were stuck in lot. During a review of a family member's concern dated 1/28/26, at 11:59 a.m. revealed the following: - It is an absolute disaster down there with snow you can't get in you can't get out. During an interview on 1/28/26, at 3:10 p.m. the Nursing Home Administrator (NHA) stated, stated the company that was contracted for snow removal never arrived on January 11 (during the snowstorm) or anytime after to maintain the grounds around the building. As of 1/28/26, the NHA stated that they are in the process of finding a contractor to remove the snow and clear the remainder parking lot and entrance. NHA stated that they did have the local road crew clear an area of the lot. During an observation on 1/28/26, at 6:10 p.m. the walkway to the Virgina Ave emergency exit and the Courtyard emergency exit were not shoveled. Both doors did open but the area was not clear to walk. During an interview on 1/28/26, at 6:22 p.m. the NHA confirmed that the facility failed to ensure the outside environment was free of potential hazards and failed to evaluate the hazard and failed to implement a plan for snow removal for two of two parking lot areas and failed to clear the walkways for two of three exits three days after a snowstorm ended.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(5) 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 01/31/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly secure a medication cart while not in use for three of four medication carts (Vineyard, Rosewood, and Rosewood 2).Findings include:Review of facility policy Medication Storage dated 12/11/25, indicated all drugs and biologicals will be stored in locked compartments (medication carts, cabinets, drawers, refrigerators, and medication rooms). During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication cart.During an observation on 1/29/26, at 10:45 a.m. the Vineyard Medication Cart and the Rosewood Medication Cart were observed sitting in the hallway, beside each other, with the cart unlocked and unattended. During an interview on 1/29/26, at 10:47 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the Vineyard Medication Cart was unlocked, unattended, and that the facility failed to properly secure a medication cart while not in use.During an interview on 1/29/26, at 10:49 a.m. Registered Nurse (RN) Employee E2 confirmed the Rosewood Medication Cart was unlocked, unattended, and that the facility failed to properly secure a medication cart while not in use.During an observation on 1/31/26, at 10:31 a.m. the Rosewood 2 Medication Cart was observed sitting in the hallway with the cart unlocked and unattended.During an interview on 1/31/26, at 10:33 a.m. RN Employee E3 stated, I was in a room, and confirmed that the Rosewood 2 Medication Cart was unlocked, unattended, and that the facility failed to properly secure a medication cart while not in use.During an interview on 1/31/26, at 1:30 p.m. the Nursing Home Administrator confirmed the facility failed to properly secure a medication cart while not in use for three of four medication carts (Vineyard, Rosewood, and Rosewood 2), as required.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1)(k) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(3)(5) 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 01/31/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Dispose of garbage and refuse properly. Based on review of facility policy, observation and staff interview it was determined that the facility failed to properly contain and dispose of garbage in outside dumpsters to prevent the potential for rodent and insect infestation.Findings include:Review of facility policy Disposal of Garbage and Refuse, dated 12/11/25, indicates that the facility shall dispose of kitchen garbage and refuse. There shall be sufficient numbers of receptacles to hold refuse where refuse is discarded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. Garbage should not accumulate or be left outside the dumpster.During an observation on 1/29/26, at 5:38 p.m. the outdoor trash compactor had two shopping carts, an oversized chair, many empty cardboard boxes, and an uncountable amount of filled garbage bags sitting around the dumpster.During an interview on 1/29/26, at 6:00 p.m. the Nursing Home Administrator confirmed that that there were trash and debris collecting in the disposal area, and that the facility failed to properly contain and dispose of garbage in the outside dumpster area to prevent potential rodent and insect infestation.28 Pa. Code 201.18(b)(3) Management.

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 01/31/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, observations, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to ensure comfortable air temperature levels (between 71-81 degrees Fahrenheit) were provided in the facility, and failed to monitor and assess all residents for hypothermia (a life-threatening medical emergency when the body loses heat faster than it can produce it), which created an Immediate Jeopardy situation, for 82 of 82 residents.Findings include:The job description for the Nursing Home Administrator dated 12/19/24, indicated the NHA leads, guides, and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards, and established facility policies and procedures to provide appropriate care and services to residents. Plans, develop, organize, implement, evaluate, and direct the overall operation of the facility. Performs rounds to observe residents and ensure overall needs are met. Participates in safety and emergency drills. Fulfills responsibilities as assigned during implementation or activation of the facility's emergency plan.The job description for the Director of Nursing dated 10/16/25, indicated the DON is to plan, organize, develop, and direct the overall operations of the nursing service department. Establish facility policies and procedures and provide appropriate care and services to the residents. Plans, develops, organizes, implements, evaluates, and directs the overall operations of the nursing services department. Performs rounds to observe residents and ensure nursing needs are being met. Fulfills responsibilities as assigned during implementation or activation of the facility's emergency plan.Based on findings identified, the facility failed to ensure comfortable air temperature levels (between 71-81 degrees Fahrenheit) were provided in the facility, and failed to monitor and assess all residents for hypothermia (a life-threatening medical emergency when the body loses heat faster than it can produce it), which created an Immediate Jeopardy situation, for 82 of 82 residents. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed.During an interview on 1/29/26, at 2:30 p.m. the NHA was notified that they failed to ensure comfortable air temperature levels (between 71-81 degrees Fahrenheit) were provided in the facility, and failed to monitor and assess all residents for hypothermia (a life-threatening medical emergency when the body loses heat faster than it can produce it), which created an Immediate Jeopardy situation, for 82 of 82 residents.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.