

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  03/21/2025
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for three of three residents (Resident R26, R37, and R56 ).</p> <p>Findings include:</p> <p>Review of facility policy Call Lights: Accessibility and Timely Response last reviewed 1/7/25, indicated all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Process for responding to call lights:</p> <ol style="list-style-type: none"> <li>a. Turn off the signal light in the resident's room.</li> <li>b. Identify yourself and call the resident by name.</li> <li>c. Listen to the residents' request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel.</li> <li>d. Inform the appropriate personnel of the resident's need.</li> <li>e. Do not promise something you cannot deliver.</li> <li>f. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives.</li> </ol> <p>Resident R26 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reivew of Resident R26's MDS (minimum data set a periodic assessment of needs) indicated a diagnosis of heart failure (condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), hypotension (condition where the force of blood pushing against the artery walls is too low), and diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high).</p> <p>During an observation on 3/17/25, at 10:34 a.m. Resident R26 call bell was observed being on for 18 minutes on the the facility call bell system.</p> <p>Resident R56 was admitted on [DATE].</p> <p>Review of Resident R56 MDS indicated a diagnosis of congestive heart failure (occurs when the heart muscle doesn't pump blood as well as it should), and hypertension (when the force of blood flowing through your blood vessels is consistently too high).</p> <p>During an observation on 3/17/25, at 10:38 a.m. Resident R56 call bell was observed being on for one hour on the the facility call bell system.</p> <p>During an interview on 3/17/25, with Registered Nurse Employee E25 confirmed that Resident R26 waiting 18 minutes and Resident R56 waiting an one hour for call bell response exceed the time frame to answer a call bell timely, and that the facility failed to answer the call bells timely.</p> <p>Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE].</p> <p>Review of Resident R37's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/12/25, indicated diagnoses of atrial fibrillation (abnormal heart rhythm), heart failure (heart doesn't pump the way it should), and hyperlipidemia (high fats in the blood)</p> <p>During an interview completed on 3/17/25, at 11:30 a.m. Resident R37 was in her bed. During this interview, Resident R37 stated, no one has come I've been pushing it constantly (referring to her call bell), I've been laying here waiting since breakfast, I'm not able to get my shower as we only had one nurse aid in the morning, some staff have come in since.</p> <p>During an observation on 3/17/25, at 11:31 a.m. the kiosk on the Hilltop hallway indicated that Resident R37's call light had been on for fifty minutes.</p> <p>During an interview completed on 3/17/25, at 11:31 a.m. Nurse Aid Employee E27 confirmed that the call bell for Resident R37 was on for fifty minutes. Nurse Aid Employee E27 also stated, I did speak with the resident earlier in the shift about her shower, she should have her shower today as more help has arrived.</p> <p>28 Pa. Code: 201.29(j) Resident rights.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(3)(5) Nursing services.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>27424</p> <p>Based on review of facility policy and documentation, resident and staff interview it was determined that the facility failed to respond the residents concerns from resident council for five of six month reviewed (September, October, November and December of 2024, and February of 2025).</p> <p>Findings include:</p> <p>Review of facility policy Resident and Family Concerns/Grievances dated 1/7/25, indicated : The Grievance Official is responsible for overseeing the grievance process; receiveing and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident.</p> <p>Review of facility documentation resident council notes indicated the following concerns:</p> <p>6/12/24: call bells(a problem answered timely), meal trays late, alternate (for meals - ability to receive).</p> <p>7/12/24: call bells takes up to an hour for a response, snack cart and meal trays late.</p> <p>8/14/24: snack cart not taken around.</p> <p>9/11/24: snack cart is hit or miss.</p> <p>10/9/24: snack cart not being delivered in the evening, meal tray carts sit and not being delivered.</p> <p>11/13/24: snack cart not being delivered, hoyer lift not being charged</p> <p>12/19/24: snack carts not being passed.</p> <p>1/8/25: no concerns</p> <p>2/19/25: would like for activites to re-group.</p> <p>During a resident group meeting, on 3/19/25, at 2:45 p.m. residents indicated the following are on-going concerns:</p> <p>call bells being answered timely ( related to staffing), meal trays and snack carts being passed timely, and the facility providing activities, and allowing residents to gather together to participate in activities. Resident indicated that they were not allowed to gather every month for resident council when the facility has COVID outbreaks. Residents stated they don't get feedback on their concerns from resident council and the above concerns continue. Residents also indicated that they don't want to attend the resident council meeting because they continue to discuss the same concerns without resolution.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/21/24, at 12:01 p. m Nursing Home Administrator confirmed that the facility failed to respond to resident concerns for six of six months.</p> <p>Pa. Code 201.18 (d) Management.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of clinical records, facility documents, and staff interviews, it was determined that the facility failed to notify the physician of a change in treatment in a timely manner for one of three residents (Resident R290).</p> <p>Findings include:</p> <p>Review of facility policy Notification of Changes dated 1/7/25, indicated the purpose of this policy is to ensure the facility promptly informs the residents, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident's physician when there is a circumstance that require a need to alter treatment.</p> <p>Review of the clinical record revealed that Resident R290 was admitted to the facility on [DATE], with diagnoses of high blood pressure, depression, and non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities.)</p> <p>Review of Resident R290's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/9/25, indicated diagnoses were current.</p> <p>Review of Resident R290's physician order dated 3/14/25, indicated to administer one liter of 5-0.45% Dextrose-Sodium Chloride (solution for fluid and electrolyte replenishment and caloric supply) at 50 milliliters/hour (ml/hr) for hypernatremia (the medical term to describe too much sodium in your blood). It was indicated to place a midline (a short catheter which is inserted into one of the superficial veins of an extremity) if needed.</p> <p>Review of Resident R290's March 2025 Medication Administration revealed Resident R290 failed to receive the one liter of 5-0.45% Dextrose-Sodium Chloride solution as ordered. It was documented midline not yet placed, unable to give.</p> <p>Review of Resident R290's clinical record failed to include evidence the physician was notified the resident did not receive intravenous (IV) fluids as ordered.</p> <p>Review of Resident R290's physician order dated 3/17/25, indicated to administer two liters of Dextrose 5% in Water (D5W-IV solution used to replace lost fluids and provide carbohydrates to the body) at 100 ml/hr for acute kidney injury and hypernatremia. It was indicated to start the IV fluids at 12:00 p.m.</p> <p>Review of Resident R290's March 2025 Medication Administration Record revealed the IV fluids ordered on 3/17/25, at 12:00 p.m. was left blank and not signed off for completion.</p> <p>Review of Resident R290's progress note dated 3/17/25, at 9:32 p.m. indicated a midline was inserted into the resident's right cephalic vein and D5W was infusing at 100 ml/hr.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R290's clinical record failed to indicate a physician was notified of the delay in administration of Resident R290's IV fluids as ordered on 3/17/25.</p> <p>Review of Resident R290's physician order dated 3/19/25, indicated to obtain a CMP (Comprehensive Metabolic Panel is a series of 14 blood tests. It gives your doctor a snapshot of how your liver and kidneys are working, your blood sugar (glucose) level, and your electrolyte and fluid balance.), CBC (Complete Blood Count complete blood count is a blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets.) with differential for acute kidney injury, hypernatremia, and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). It was indicated facility staff must draw.</p> <p>Review of Resident R290's clinical record failed to include evidence Resident R290's lab work was obtained as ordered on 3/19/25, by facility staff.</p> <p>During an interview on 3/20/25, at 11:26 a.m. the Nursing Home Administrator confirmed the facility failed to notify Resident R290's physician of the failure to administer the IV fluids on 3/14/25, delayed administration of IV fluids on 3/17/25, and failure to obtain labs on 3/19/25, as ordered.</p> <p>During an interview on 3/20/25, at 2:25 p.m. Medical Doctor, Employee E39 stated he was under the assumption Resident R290 was provided all the IV fluids and lab work as ordered. Medical Doctor, Employee E39 confirmed the facility failed to notify a physician of Resident R290's missed and delayed treatment.</p> <p>28 Pa. Code: 201.14(a)(c) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policy, resident clinical record, documentation provided by the facility, and staff interview it was determined that the facility failed to report an allegation of possible neglect within 24 hours to the local state field office for one of seven residents (Resident R30).</p> <p>Findings include:</p> <p>Review of facility policy Abuse Neglect, and Exploitation last reviewed 1/7/25, indicated the facility will provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. An immediate investigation is warranted when suspicion of abuse, or neglect occurs. It was indicated all persons, including witnesses, and others who might have the knowledge of the allegation must be identified and interviewed. A complete and thorough documentation of the investigation must be conducted. The facility will have written procedures that include reporting of all alleged violations to the Administrator, State Agency, adult protective services and to all other required agencies within specified timeframes:</p> <p>a) Immediately , but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or.</p> <p>b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Review of the facility policy Incidents and Accidents last reviewed 1/7/25, indicated the facility staff will report, investigate, and review any accidents or incidents that occur on facility property and may involve a resident. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root cause. Incidents that require an incident report include observed accidents/incidents, choking, and self-inflicted and unobserved injuries. The supervisor will be notified of the incident, and the nurse will contact the resident's practitioner to inform them of the incident, report any injuries, and obtain orders, if indicated. The nurse will enter the incident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. Documentation should include the date, time, nature of incident, location, initial findings, immediate interventions and will document all pertinent information.</p> <p>Review of Resident R30's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 1/28/25, indicated diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition), dementia (the loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R30's care plan dated 2/29/24, indicated the resident exhibits behaviors symptoms such as wandering the unit and in and out of resident rooms, placing items in mouth, due to dementia, cognitive impairment, and PICA (an eating disorder where a person compulsively eats things that aren ' t food and don ' t have any nutritional value or purpose). Interventions included to praise and reinforce while gently redirecting out of other rooms, notify physician of negative behavior or activity.</p> <p>Review of Resident R30's progress note dated 2/28/25, at 5:10 p.m. indicated the resident was found in the sun room. Resident R30 took a bite out of a gold glitter Styrofoam coin. Resident still had pieces of Styrofoam in her mouth. Resident would not allow nurse to attempt to remove them. Gave resident three spoonful's of pudding to allow resident to swallow without choking on pieces.</p> <p>Review of documentation provided to the local state field office from 2/28/25, to 3/20/25, did not include Resident R30's incident of possible neglect.</p> <p>During an interview on 3/20/25, at 9:33 a.m. the Nursing Home Administrator confirmed that the facility failed to report Resident R30's incident of within 24 hours to the local state field office as required for one of seven residents (Resident R30).</p> <p>28 Pa. Code: 201.14(a)(c) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa Code: 201.18 (b)(1)(e)(1) Management.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to conduct a thorough investigation of an incident to rule out possible neglect for one of seven residents (Resident R30).</p> <p>Findings include:</p> <p>Review of facility policy Abuse Neglect, and Exploitation last reviewed 1/7/25, indicated the facility will provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. An immediate investigation is warranted when suspicion of abuse, or neglect occurs. It was indicated all persons, including witnesses, and others who might have the knowledge of the allegation must be identified and interviewed. A complete and thorough documentation of the investigation must be conducted.</p> <p>Review of the facility policy Incidents and Accidents last reviewed 1/7/25, indicated the facility staff will report, investigate, and review any accidents or incidents that occur on facility property and may involve a resident. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root cause. Incidents that require an incident report include observed accidents/incidents, choking, and self-inflicted and unobserved injuries. The supervisor will be notified of the incident, and the nurse will contact the resident's practitioner to inform them of the incident, report any injuries, and obtain orders, if indicated. The nurse will enter the incident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. Documentation should include the date, time, nature of incident, location, initial findings, immediate interventions and will document all pertinent information.</p> <p>Review of Resident R30's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 1/28/25, indicated diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition), dementia (the loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.), and eating disorder.</p> <p>Review of Resident R30's care plan dated 2/29/24, indicated the resident exhibits behaviors symptoms such as wandering the unit and in and out of resident rooms, placing items in mouth, due to dementia, cognitive impairment, and PICA (an eating disorder where a person compulsively eats things that aren ' t food and don ' t have any nutritional value or purpose). Interventions included to praise and reinforce while gently redirecting out of other rooms, notify physician of negative behavior or activity.</p> <p>Review of Resident R30's progress note dated 2/28/25, at 5:10 p.m. indicated the resident was found in the sun room. Resident R30 took a bite out of a gold glitter Styrofoam coin. Resident still had pieces of Styrofoam in her mouth. Resident would not allow nurse to attempt to remove them. Gave resident three spoonful's of pudding for resident to swallow without choking on pieces.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility list of incidents on 3/19/25, at 1:34 p.m. failed to include Resident R30's incident of ingesting a foreign body.</p> <p>During an interview on 3/20/25, at 9:33 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct a thorough investigation of an incident to rule out possible neglect for one of seven residents (Resident R30), involving the ingestion of a foreign body on 2/28/25.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa Code: 201.18 (b)(1)(e)(1) Management.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>27424</p> <p>Based on review of facility documentation, resident and staff interview it was determined that the facility failed to provide ongoing program of activities to meet the interest of and support the physical, mental, and psychosocial well-being of each resident for four of four residents:</p> <p>Findings include:</p> <p>Review of activity calendar for March 17th through March 21, 2025, revealed:</p> <p>Bible study:</p> <p>Manicures:</p> <p>Observations on 3/19/25, at 10:30 a.m. bible study was on the activity calendar observations in the activity room at 10:40 a.m. Showed two residents watching a movie in the activity room.</p> <p>Resident group interview on 3/19/25, at 3:00 p.m. residents indicated that the activities program was not meeting their needs.</p> <p>-Residents stated that they do not consistently get together for activities or resident council. - Residents stated that they can't always gather for activities due to COVID.</p> <p>-Residents requested to re- start activites from February resident council meeting and this had not been met.</p> <p>-Residents indicated they wanted to do activities to include: going outside, going to restaurants and shopping, getting together in groups, going for ice cream, and going to ball games. When asked about the activities calendar the residents stated that they don't do activities together.</p> <p>Observations on 3/21/25, at 10:23 a.m. noted the Activity Director Employee E15 going into resident room while manicures were listed on the activity calendar for 10:00 a.m. When asked when did manicures take place, Activity Director Employee E15 indicated that they were done.</p> <p>Review of facility documentation - showed four residents receiving manicures - no other residents received manicures.</p> <p>During an interview on 3/21/25, at 12:01 p.m. with Nursing Home Administrator confirmed that the facility failed to provide ongoing program of activities to meet the interest of and support the physical, mental, and psychosocial well-being of each resident for four of four residents.</p> <p>28 Pa. Code 201.18 (3) Management.</p>		

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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	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to document assessment and notify the physician of a change in condition for one of four residents (Resident R80).</p> <p>Findings include:</p> <p>Review of the facility policy Notification of Changes dated 1/7/25, indicated the facility will promptly inform the resident, consult the resident's physician, and notify the resident's representative when there is a change requiring notification.</p> <p>Review of the admission record indicated Resident R80 admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/28/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and high blood pressure.</p> <p>Review of Resident R80's physician order dated 2/24/25, indicated dialysis every Monday, Wednesday, and Friday.</p> <p>Review of Resident R80's care plan dated 2/20/25, indicated resident is on anticoagulant therapy (medications that prevent blood from clotting) related to cerebral vascular accident (damage to the brain from an interruption of blood supply). Monitor for signs and symptoms of bleeding and notify physician for any complications.</p> <p>Observation on 3/17/25, at 9:36 a.m. Resident R80 was in the wheelchair in the hallway with an active nosebleed. Resident R80 was holding a tissue to his nose.</p> <p>Interview on 3/17/25, at 9:40 a.m. Registered Nurse (RN) Employee E20 indicated Resident R80 had an active nosebleed, his blood pressure was high, and that he missed dialysis today.</p> <p>Review of Resident R80's progress note dated 3/17/25, at 1:26 p.m. indicated resident did not go to dialysis today. The progress notes failed to include the nosebleed, an assessment of the active nosebleed, failed to include a blood pressure reading, and failed to have notification to the physician of the symptoms or of Resident R80 not attending dialysis that day.</p> <p>Interview with the Director of Nursing on 3/17/25, at 2:30 p.m. confirmed the facility failed to document assessment and notify the physician of a change in condition for one of four residents (Resident R80).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for one of four residents (Resident R32).</p> <p>Findings include:</p> <p>Review of the Code of Federal Regulations (CFR) S483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Review of the admission record indicated Resident R32 was admitted to the facility on [DATE].</p> <p>Review of Resident R32's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/25, indicated the diagnoses of non-Alzheimer's dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, and high blood pressure.</p> <p>Review of Resident R32's physician order dated 2/11/25, indicated right resting hand splint (positions the hand in a way that provides a stretch to connective tissues to reduce spasticity) put on with morning care and take off with evening care. Skin checks to be completed upon application and removal of splint.</p> <p>Review of Resident R32's current care plan on 3/20/25, indicated resident has the potential to improve range of motion as evidenced by decreased range of motion due to activity intolerance. Resident will participate in a passive range of motion restorative nursing program and will attain right upper extremity-shoulder flexion adduction (movement toward midline of the body), external rotation, elbow extension and supination (rolling outward) of the wrist.</p> <p>Observation on 3/20/25, at 9:45 a.m. Resident R32 was observed in room with a blue washcloth rolled in the right hand.</p> <p>Interview on 3/20/25, at 9:59 a.m. Occupational Therapist Employee E22 indicated we do not have a restorative program here.</p> <p>Interview on 3/20/25, at 10:09 a.m. Registered Nurse (RN) Employee E23 confirmed the splint was not in place, the care plan was not reflective of current treatment, and the facility does not have a restorative program.</p> <p>Interview on 3/20/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide treatment and services to prevent further decrease in range of motion for one of four residents (Resident R32).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and failed to identify a resident who was an elopement risk, failed to re-evaluate residents for elopement risk, which resulted in an elopement for two of eleven residents (Residents R79 and R289) and transfer to a local hospital, then to a level one trauma center for one of eleven residents (Resident R289). This failure created an immediate jeopardy situation for two of 11 residents (Resident R79 and R289).</p> <p>Findings include:</p> <p>Review of the facility policy Elopements and Wandering Residents dated 1/7/25, indicated that the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.</p> <p>Review of the admission record indicated Resident R79 was admitted on [DATE].</p> <p>Review of Resident R79's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 12/29/24, indicated diagnoses of Alzheimer's (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.), dementia (loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), and non-exudative age-related macular degeneration (AMD- common eye condition that primarily affects older adults, leading to a gradual loss of central vision). The residents Brief Interview for Mental Status (BIMS) assessment was 7, severely cognitively impaired.</p> <p>Review of an Elopement Risk Evaluation dated 12/28/24, indicated Resident R79 was a high elopement risk.</p> <p>Review of Resident R79's care plan dated 12/30/24, indicated Resident R79 was care planned for elopement. The care plan failed to include supervision as an intervention.</p> <p>Review of progress note dated 12/18/24, indicated Resident R79 was ambulating through hallway with walker attempting to figure out codes to exits to find her way out. Wander guard applied to the left wrist after verifying function. Resident R79 was attempting to obtain the codes to the exits and wanted to go home.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 2/6/25, at 5:01 p.m. revealed staff heard alarm sounding on the 4th floor at 3:05 p.m. Resident R79 was observed in the stairwell. Staff assisted Resident R79 back to the unit. An assessment was completed with no injuries observed. The resident's responsible party and certified registered nurse practitioner (CRNP) were notified. There were no new orders.</p> <p>Review of information submitted to the Department of Health on 2/7/25, indicated on 2/6/25, Resident R79 eloped from the 4th floor at 3:05 p.m. It was indicated Resident R79 was in the stairwell. Staff assisted the resident back to the unit. The resident's wander guard (system designed to support the safety and independence of patients by monitoring their movements and gently preventing them from unintentionally leaving) was in place at the time of the event and was functioning appropriately. The Registered Nurse completed an assessment with no injuries observed. The resident was able to move extremities, and no pain or bruising was noted. The resident's responsible party and physician were notified. There were no new orders. It was indicated elopement assessments and care plans were updated.</p> <p>Review of Nurse Aide, Employee E14's witness statement dated 2/6/25, indicated at 3:05 p.m. an alarm was going off in the back stairwell. NA, Employee E14 opened the door and saw Resident R79 sitting on a step three floors down. NA, Employee E14 notified staff.</p> <p>Review of Nurse Aide, Employee E18's witness statement dated 2/6/25, indicated while giving report to NA, Employee E19, NA, Employee E14 came up to the nursing station and said a resident went down the stairwell. NA, Employee E18 and E19 looked at the call bell system and noticed Resident R79's call light was not on. NA, Employee E14, E18, and E19 ran down the hall to get the resident. Resident R79 made it about five flights of steps between the 3rd and 2nd floor. NA, Employee E18 took the resident back to the 4th floor using the elevator. The nurse and Director of Nursing were notified.</p> <p>Review of NA, Employee E19's witness statement dated 2/6/25, indicated at 3:05 p.m. NA, Employee E14 stated Resident R79 was observed past the third floor in the stairwell. NA, Employee E18 escorted Resident R79 to the third floor, and took the elevator back up to the fourth floor.</p> <p>During an interview on 3/18/25, at 10:15 a.m. Licensed Practical Nurse, Employee E31 was notified by staff on 2/6/25, Resident R79 was found in the stairwell. When LPN, Employee E31 went to assess Resident R79, Resident R79 was being brought back to the unit by a nurse aide. LPN, Employee E31 stated earlier that day Resident R79 was observed coming out of their room and seemed confused earlier in the day. Resident R79's room was located near the door at the end of the hallway. Resident R79 eloped during a change in shift.</p> <p>During an interview on 3/18/25, at 9:40 a.m. NA, Employee E18 stated Resident R79 eloped down the stairwell during shift change on 2/6/25. NA, Employee E18 indicated Resident R79 was observed down five flights of stairs. Resident R79 was throwing the walker down the steps. NA, Employee E18 indicated Resident R79 was tired after returning to the unit. NA, Employee E18 indicated the button on the stairwell was not working and maintenance was called to get it fixed. Resident R79's room was not changed.</p> <p>During an interview on 3/18/25, at 9:51 a.m. Director of Maintenance, Employee E32 indicated the door's egress (system used to provide a safe and accessible exit route in case of an emergency) and magnetic locks weren't working properly on 2/6/25. The facility had a company come the night Resident R79 eloped to take care of situation. The door got repaired around 1:00 a.m. on 2/7/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/25, at 10:39 a.m. Registered Nurse, Employee E34 stated on 2/6/25, it was reported that Resident R79 was found in the stairwell. Resident R79 had tossed the walker down the stairs.</p> <p>During an interview on 3/18/25, at 10:57 a.m. the Nursing Home Administrator (NHA) confirmed the facility failed to supervise Resident R79 and prevent an elopement on 2/6/25. The NHA confirmed the facility failed to update Resident R79's care plan for elopement.</p> <p>Resident R289 was admitted to the facility on [DATE], with the diagnoses of heart failure (heart doesn't pump blood as well as it should), UTI (urinary tract infection), non-Alzheimer's Dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), depression, and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe).</p> <p>Review of Resident R289's MDS dated [DATE], indicated the diagnoses remained current.</p> <p>Section C indicated a BIMS score of 10 (Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment). A score of 8-12 indicates moderately impaired cognition.</p> <p>Section GG question Q - Does the resident use a wheelchair and/or scooter - Yes.</p> <p>Question R - Wheel 50 feet with two turns: once seated in wheelchair/scooter the ability to wheel at least 50 feet and make two turns indicated resident can do with supervision or touching assistance.</p> <p>Question S - Ability to wheel 150 feet once seated in wheelchair/scooter the ability to wheel at least 150 feet in a corridor or similar place indicated resident can do with supervision or touching assistance.</p> <p>Review of elopement risk evaluation dated 3/2/25, indicated Resident R289 was not at risk for elopement.</p> <p>Review of R289's clinical documentation progress notes indicated the following:</p> <ul style="list-style-type: none"> <li>- 3/1/25, 11:04 p.m. Resident stated that she was able to walk. Per report, husband stated that she could stand but was non-ambulatory.</li> <li>-3/2/25, at 1:40 a.m. Resident asked earlier when her husband was coming to get her.</li> <li>-3/3/25, at 2:23 a.m. Resident was alert and verbal with confusion, she continued to ask when her husband was coming to get her. Required frequent reminders regarding location and situation.</li> <li>-3/4/25, at 8:30 a.m. Resident was unable to verbalize reason for fall. Stated that she needed to go on down there.</li> <li>-3/4/25, at 1:13 p.m. Resident room changed to 353 B due to resident increase in falls and baseline confusion.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-3/10/25, at 5:30 p.m. this nurse was alerted by Physical Therapist (PT) Employee E4 that resident had fallen down emergency exit steps. She was assessed and assisted into her wheelchair and carried up ten stairs with maximum assistance. Orders received and implemented to send her to the emergency room (ER) for further evaluation.</p> <p>-3/10/25, at 9:44 p.m. spoke with ER nurse at local hospital, resident being transferred to a level one trauma center for further evaluation at that time.</p> <p>Review of facility provided witness statements indicated the following:</p> <p>PT Employee E4 indicated she was in the gym charting with the doors closed due to it being the end of the day. She heard some loud thuds and bangs nearby and went to check where the noise came from. She looked through the window to the stairwell by the gym and saw Resident R289 lying down the stairs on the landing on her right side with her wheelchair down by her feet. PT Employee E4 ran to get a nurse.</p> <p>Licensed Practical Nurse (LPN) Employee E5 indicated she was alerted by PT that a resident fell down the stairs in her wheelchair. Found resident lying at the bottom of stairs in stairwell. Resident was out of her wheelchair lying on her right side. A little diaphoretic (sweaty) and somewhat incoherent. EMS (emergency medical services) called.</p> <p>Nurse Aide (NA) Employee E6 indicated at 5:20 p.m. she was passing trays and noticed Resident R289 was not by the nurse's station where she was a few minutes prior. The alarm was going off so she and NA Employee E7 started checking doors, arrived at the Pub's door and resident was in stairwell with the nurses.</p> <p>NA Employee E7 indicated at the end of passing the second cart they heard an alarm go off and she and NA Employee E6 went to stair wells and didn't see anyone. A nurse was putting food in the fridge over in the cafe end of the floor and stated Resident R289 fell down the steps.</p> <p>During a telephonic interview on 3/17/25, at 1:51 p.m. PT Employee E4 indicated I heard a bunch of noise. I was in the therapy room with the door shut. It was around dinner time and the aides were passing trays. Something was crashing or falling nearby, I looked for where the noise was and there was a glass window I glanced down because there was nothing in hall. Resident R289 was on the landing on the floor below. She was on the landing, fell down ten steps and the wheelchair was with her. I ran to get a nurse. The first noise I heard was a banging crash, the first nurse I grabbed (LPN Employee E5) ran with me and stayed with the resident. She was not her nurse, so I ran a second time to get the patients nurse (Registered Nurse, RN Employee E8). The wheelchair was on its side on top of her legs, she was on her side on the landing and the wheelchair was on its side. I've seen Resident R289 in the lobby area, I did work with her for physical therapy. I saw her that day and she was due for a report. I reviewed her goals, resident stated I'm glad I'm making progress because I want to go.</p> <p>Telephonic interview attempted with LPN Employee E5 on 3/21/25, at 11:52 a.m. unsuccessfully and voice mail was full.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/25, at 9:42 a.m. NA Employee E6 indicated Resident R289 said she wanted to go home. She's been saying that ever since she got here. She did not have a wanderguard. At the time we were picking up a second food cart and Resident R289 was out front at the desk. I was taking the cart back around the corner and Resident R289 said I want to go home. I told her let's eat dinner first and then we'll talk about it. When I came back Resident R289 was gone. At that time, I didn't tell the nurse because she wasn't in the hallway then I would have to find her which would take how long.</p> <p>During an interview on 3/18/25, at 11:31 a.m. NA Employee E7 indicated the type of residents they've been bringing in here are more confused residents, and it was dinner time. Resident R289 was saying she wanted to go home the same week she came. Said we were keeping her hostage, and she was saying she wanted to leave. Everyone was noticing Resident R289 was saying that. She was starting to show it in the hallway roaming. Resident R289 was at the nurses desk by her room, but more by the desk. We just got the second cart, and we were passing it. We heard the alarm. I ran to one stairwell and NA Employee E6 ran to the other steps. That's when therapy found her at the other stairway down the steps.</p> <p>During a telephonic interview on 3/17/25, at 2:28 p.m. RN Employee E8 indicated I was passing my meds as RN Supervisor; I think therapy put her in her chair and Resident R289 was asking about dinner to some staff. I said what's wrong, Ms. Resident R289 She said I'm not talking to you. The therapist came to get me and said she fell down the steps. I went straight to the stairwell. I saw her lying down ten steps on the landing with her wheelchair. There were other nurses there when I arrived. Resident was laying on her side/belly and she was alert. I did text the Assistant Director of Nursing (ADON) Employee E9 because one of the aides expressed concern for her needing a wander guard. Before I knew it, she was at the bottom of the steps, maybe within ten minutes of me texting the ADON.</p> <p>During an interview on 3/17/25, at 12:22 p.m. Assistant Director of Nursing (ADON) Employee E9 indicated RN Employee E8 called me ten minutes prior to the incident asking where the wander guards were kept because Resident R289 was acting agitated and asking about the elevators which was new for her. RN Employee E8 called me back about ten minutes later and stated Resident R289 went to the Pub, opened the door in her wheelchair. The magnetic lock has a fire safety mechanism that if pushed on long enough will open up as a fire safety rule. Someone in therapy heard a noise and found Resident R289 at bottom of stairs.</p> <p>During an interview on 3/18/25, at 1:55 p.m. the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed that Resident R289 was in the hallway, pressed the doorway to release the fire alarm on the doorway, wheeled self through doorway and went down the stairs in her wheelchair and the facility failed to identify elopement risk behaviors timely.</p> <p>The DON and NHA were made aware that an Immediate Jeopardy situation existed for residents on 3/18/25, at 1:55 p.m. and an immediate action plan was requested.</p> <p>On 3/18/25, at 1:55 p.m. the Immediate Jeopardy template was provided to the facility administration.</p> <p>On 3/18/25, at 4:32 p.m. an acceptable Corrective Action Plan was received which included the following interventions:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediate Action:</p> <p>Resident R79 was returned safely to her room by staff and assessed by RN. No injuries observed and no pain voiced by resident. Elopement risk evaluation updated, and care plan updated to include resident preferences and any triggers for exit seeking behavior. Care plan also updated to include remaining safe on my unit and free of elopements through next review.</p> <p>Cited Resident R289 dated 3/10/25 is no longer in facility and no longer expected to return. Family collected personal belongings.</p> <p>Root cause analysis identified as staff did not report exit seeking behavior timely and facility failed to provide appropriate supervision.</p> <p>Residents:</p> <p>All residents will have updated elopement risk evaluations completed by DON or designee by 3/19/25.</p> <p>Care plan interventions for residents identified for elopement risk will be implemented by ensuring staff are provided with person centered interventions. This will be completed by DON or designee by 3/19/25.</p> <p>Care plan goals for residents who are identified for elopement risk updated to include remaining safe on the unit through staff supervision and free of elopements through next review. This will be completed by DON or designee by 3/19/25.</p> <p>System Correction:</p> <p>Whole house education on elopement risks and assessments, supervision, and care plans of residents. This education includes agency staff and staff will be educated prior to their next scheduled shift. This will be completed by NHA or designee by 3/20/25.</p> <p>Review and update the elopement policy as needed by end of day 3/19/25.</p> <p>Monitoring:</p> <p>Audits of new exit seeking behaviors will be conducted by DON or designee daily x 2 weeks, weekly x 2 weeks, then monthly x 2 months to ensure evaluations and care plans are up to date. Findings of audits will include updated elopement evaluations and care plan goals/interventions. Ongoing results will be submitted to QA.</p> <p>Immediate Jeopardy was lifted on 3/19/15, at 1:53 p.m. and the abatement plan was verified as follows:</p> <p>-88/88 Residents were assessed for risk of elopement on 3/18/25. Two residents were newly admitted after IJ was called and the facility completed an elopement assessment. The residents were not identified as a risk. Total of 90/90 residents were assessed for elopement risk.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-12/12 Residents identified as an elopement risk through assessment. 12/12 Resident care plans were updated on 3/18/25, with interventions to prevent elopement, including supervision of the resident. Review of assessments identified one resident was newly identified as an elopement risk from entrance. The resident was added to elopement binders.</p> <p>-12/12 Resident care plan goals were updated to I will remain safe on the unit through staff supervision and free of elopements through next review.</p> <p>-106/138 in-house staff were educated on elopement risks and assessments, supervision, and care plans of residents. The facility utilizes two agency companies. 24/24 agency staff were educated. 36/36 in-person interviews were completed and confirmed staff were educated. 7/7 telephonic interviews conducted revealed staff received education. Staff were educated on the importance of supervision of residents, exit-seeking behaviors as well as when to reevaluate residents for an elopement risk. All staff must verify education prior to the start of their next shift.</p> <p>-Elopement and Wandering Residents policy was reviewed and revised on 3/18/25. It was indicated care plan goals will include remaining free of elopements by supervision. Adequate supervision will be provided to help prevent accidents or elopements.</p> <p>-An audit of residents with newly identified exit seeking behaviors was completed on 3/18/25, and 3/19/25. No residents were observed with exit seeking behaviors.</p> <p>-The facility's next scheduled QA meeting is 3/26/25.</p> <p>During an exit interview on 3/21/25, at 2:45 p.m. information was disseminated to the Director of Nursing (DON), Nursing Home Administrator (NHA), and the Corporate [NAME] President of Operations Employee E26 that the facility failed to make certain each resident received adequate supervision and failed to identify a resident who was an elopement risk, failed to re-evaluate residents for elopement risk, which resulted in an elopement for two of eleven residents (Residents R79 and R289) and transfer to a local hospital, then to a level one trauma center for one of eleven residents (Resident R289) and this failure created in an immediate jeopardy situation potentially placing residents at risk of harm or injury for two of 11 residents (Resident R79 and R289).</p> <p>28 Pa. Code: 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on facility policy, clinical record review, and interview, the facility failed to develop an individualized care plan for the use of a urinary catheter (insertion of a tube into the bladder to remove urine) for one of six residents (R64) and failed to provide privacy for the collection bags for four of six residents reviewed (Residents R32, R34, R51, and R64).</p> <p>Findings include:</p> <p>Review of facility policy Comprehensive Care Plans dated 1/7/25, indicated it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meets professional standards of quality.</p> <p>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.</p> <p>Review of the admission record indicated Resident R32 was admitted to the facility on [DATE].</p> <p>Review of Resident R32's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/25, indicated the diagnoses of non-Alzheimer's dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), and high blood pressure.</p> <p>Review of Resident R32's physician order dated 10/27/24, indicated catheter care for suprapubic catheter (a thin, flexible tube inserted directly into the bladder through a small incision in the lower abdomen) every shift.</p> <p>Review of Resident R32's current care plan indicated to cover catheter bag with bag cover.</p> <p>Observation on 3/20/25, at 9:00 a.m. indicated Resident R32 in bed with a catheter collection bag full of urine clearly visible without a privacy bag.</p> <p>Interview and observation on 3/20/25, at 9:00 a.m. Licensed Practical Nurse (LPN) Employee E29 confirmed that Resident R32 did not have a privacy bag as required.</p> <p>Review of Admission record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R34's MDS dated [DATE], indicated diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), high blood pressure, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of Resident R34's physician order dated 3/11/25, indicated foley catheter 16 French 10 cc (cubic centimeter) balloon. Change monthly.</p> <p>Review of Resident R34's current care plan indicated Resident has an indwelling foley catheter for pressure ulcer.</p> <p>Observation on 3/20/25, at 1:40 p.m. indicated Resident R34 walking in the hallway with a walker. The catheter collection bag was full of urine clearly visible without a privacy bag, hanging off the resident's walker.</p> <p>Interview and observation on 3/20/25, at 1:40 p.m. Therapy Employee E30 confirmed the collection bag was hanging off the walker full of urine clearly visible without a privacy bag as required.</p> <p>Review of the admission record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's MDS dated [DATE], indicated the diagnoses of hypertension (high blood pressure), neurogenic bladder (loss of bladder control), and benign prostatic hyperplasia (BPH- enlargement of the prostate gland).</p> <p>Review of Resident R51's physician orders dated 1/15/25, indicates 16 French 10cc balloon foley catheter for neurogenic bladder.</p> <p>Review of Resident R51's physician order dated 2/26/25, indicated keep foley drainage bag covered at all times.</p> <p>Observation on 3/17/25, at 10:04 a.m. Resident R51 was in bed with a catheter collection bag full of urine clearly visible without a privacy bag.</p> <p>During an interview completed on 3/17/25, at 10:29 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the catheter collection bag was not covered with a privacy bag.</p> <p>Review of Resident R64's admission record indicated that she was admitted to the facility 11/3/22.</p> <p>Review of Resident R64's MDS dated [DATE], indicated diagnoses of diabetes mellitus (a metabolic disorder in which the body has high blood sugar levels for extended periods of time), respiratory failure, and kidney failure.</p> <p>Review of Resident R64's physician order dated 2/6/25, indicated 16 French 5cc balloon foley catheter for aggressive diuretic therapy due to congestive heart failure.</p> <p>Review of Resident R64's current care plan failed to address care and services related to the use of a foley catheter.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/20/25, at 1:50 p.m., Registered Nurse Assessment Coordinator (RNAC) Employee E36 confirmed that Resident R64's current care plan failed to address care and services for foley catheter use.</p> <p>Review of Resident R64's physician order dated 2/26/25, indicated to keep foley drainage bag covered at all times.</p> <p>Observation on 3/21/25, at 1:35 p.m., Resident R64 was in bed with a catheter collection bag containing urine clearly visible without a privacy bag.</p> <p>Interview on 3/21/25, at 1:40 p.m., RN Employee E23 confirmed the facility failed to provide privacy for the collection bags for four of six residents reviewed (Residents R32, R34, R51, and R64).</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</b></p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to identify and address significant weight loss in a timely manner for one out of seven residents (R38), failed to develop or update an individualized nutrition care plan for two out of seven residents (R1 and R38), and failed to timely assess the nutritional status of four out of seven residents (Residents R1, R9, R38, and R64).</p> <p>Findings include:</p> <p>Review of facility policy Nutritional Management dated 1/7/2025, indicated a comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. Follow-up assessments will be completed as needed. The assessment shall clarify the resident's current nutritional status and individual risk factors for altered nutrition/hydration. The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care. Interventions will be individualized to address the specific needs of the resident. Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. The care plan will be updated as needed, such as when a resident's condition changes, goals are met or the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of nutrition-related problems are identified.</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:</p> <p>- Section K0300: significant weight loss is defined as 5% weight loss or more in 30 days or 10% weight loss or more in 180 days</p> <p>GUIDANCE S483.25(g)</p> <p>Significant weight loss is defined as:</p> <p>5% or greater in one month</p> <p>7.5% or greater in three months</p> <p>10% or greater in six months</p> <p>Review of Resident R1's admission record indicated that she was admitted to the facility 4/5/24.</p> <p>Review of Resident R1's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 2/19/25, indicated diagnoses of bipolar disorder (a serious mental illness characterized by extreme mood swings), chronic kidney disease, and diabetes mellitus (a metabolic disorder in which the body has high blood sugar levels for extended periods of time).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident R1's MDS assessment dated [DATE], indicated in Section A0310: Type of Assessment, A. Federal OBRA Reason for Assessment, was coded 03 Annual Assessment.</p> <p>Review of Resident R1's clinical record failed to reveal that a comprehensive nutritional assessment was completed addressing her nutritional status for Annual MDS dated [DATE].</p> <p>Review of Resident R1's clinical record failed to reveal documentation of nutritional status monitoring associated with MDS dated [DATE].</p> <p>Further review of Resident R1's clinical record failed to reveal any Medical Nutrition Therapy documentation since 8/20/24.</p> <p>Further review of Resident R1's clinical record failed to indicate that a nutrition care plan was developed to address resident's current nutritional status.</p> <p>During an interview on 3/19/25, at 12:37 p.m., Dietetic Technician Registered (DTR) Employee E28 confirmed that she failed to assess and clinically document Resident R1's nutritional status since 8/20/24, and that she must have missed documentation due to her workload.</p> <p>Review of Resident R9's admission record indicated that she was admitted to the facility 9/1/05.</p> <p>Review of Resident R9's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 2/20/25, indicated diagnoses of bipolar disorder (a serious mental illness characterized by extreme mood swings), and dementia.</p> <p>Further review of Resident R9's MDS assessment dated [DATE], indicated in Section A0310: Type of Assessment, A. Federal OBRA Reason for Assessment, was coded 03 Annual Assessment. Section K0520: Nutritional Approaches, mechanically altered diet was checked, indicating that While a Resident in the past 7 days, this nutritional approach was performed.</p> <p>Review of Resident R9's clinical record failed to reveal that a comprehensive nutritional assessment was completed addressing her nutritional status and mechanically altered diet for Annual MDS dated [DATE].</p> <p>Review of Resident R9's clinical record failed to reveal documentation of nutritional status monitoring associated with MDS dated [DATE].</p> <p>Further review of Resident R9's clinical record failed to reveal any Medical Nutrition Therapy documentation since 9/1/24.</p> <p>Review of Resident R38's admission record indicated that she was admitted to the facility 11/2/23.</p> <p>Review of Resident R38's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 2/12/25, indicated diagnoses of schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder) and adult failure to thrive (refers to a decline seen in older adults, often accompanied by weight loss, muscle wasting, fatigue, and decreased overall quality of life).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R38's Clinical Weight Summary on 3/20/25, at 12:15 p.m., revealed the following:</p> <ul style="list-style-type: none"> <li>- 3/1/25 -- 127.2 # (pounds)</li> <li>- 2/6/25 -- 134.4 #</li> </ul> <p>= 5.4% (7.2#) weight loss in 1 month or 30 days</p> <p>Review of Resident R38's clinical record on 3/20/25, at 12:20 p.m., failed to reveal documentation that resident's current monthly loss in weight and nutritional status were addressed timely.</p> <p>Review of Resident R38's MDS assessment dated [DATE], indicated in Section K0300: Weight Loss was coded with Yes, indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months.</p> <p>Review of Resident R38's clinical record failed to reveal documentation of nutritional status monitoring associated with resident's weight loss as captured by MDS dated [DATE].</p> <p>Review of Resident R38's MDS assessment dated [DATE], indicated in Section K0300: Weight Loss was coded with Yes, indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months.</p> <p>Review of Resident R38's clinical record failed to reveal documentation of nutritional status monitoring associated with resident's weight loss as captured by MDS dated [DATE].</p> <p>Further review of Resident R38's clinical record failed to reveal any Medical Nutrition Therapy documentation since 8/6/24.</p> <p>Review of Resident R38's clinical record failed to reveal that a comprehensive care plan was updated to address resident's significant weight loss as captured by 11/12/24, and 2/12/25 MDS's.</p> <p>Review of Resident R64's admission record indicated that she was admitted to the facility 11/3/22.</p> <p>Review of Resident R64's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 3/4/25, indicated diagnoses of diabetes mellitus (a metabolic disorder in which the body has high blood sugar levels for extended periods of time), respiratory failure, and kidney failure.</p> <p>Further review of Resident R64's MDS assessment dated [DATE], indicated in Section K0520: Nutritional Approaches, therapeutic diet was checked, indicating that While a Resident in the past 7 days, this nutritional approach was performed.</p> <p>Review of Resident R64's clinical record failed to reveal documentation that a nutritional assessment was completed addressing her nutritional status and therapeutic diet for MDS dated [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R64's MDS assessment dated [DATE], indicated in Section A0310: Type of Assessment, A. Federal OBRA Reason for Assessment, was coded 03 Annual Assessment. Section K0520: Nutritional Approaches, therapeutic diet was checked, indicating that While a Resident in the past 7 days, this nutritional approach was performed.</p> <p>Review of Resident R64's clinical record failed to reveal that a comprehensive nutritional assessment was completed addressing her nutritional status and therapeutic diet for Annual MDS dated [DATE].</p> <p>During an interview on 3/20/25, at 12:23 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to identify and address significant weight loss in a timely manner for one out of seven residents (R38), failed to develop or update an individualized nutrition care plan for two out of seven residents (R1 and R38), and failed to timely assess the nutritional status of four out of seven residents (R1, R9, R38, and R64).</p> <p>28 Pa. Code: 201.18(b)(1)(e)(1)Management.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of policy and clinical records, staff and resident interview, it was determined that the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one of three residents (R290).</p> <p>Findings include:</p> <p>Review of the clinical record revealed that Resident R290 was admitted to the facility on [DATE], with diagnoses of high blood pressure, depression, and non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities.)</p> <p>Review of Resident R290's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/9/25, indicated diagnoses were current.</p> <p>Review of Resident R290's physician order dated 3/14/25, indicated to administer one liter of 5-0.45% Dextrose-Sodium Chloride (solution for fluid and electrolyte replenishment and caloric supply) at 50 milliliters/hour (ml/hr) for hypernatremia (the medical term to describe too much sodium in your blood). It was indicated to place a midline if needed.</p> <p>Review of Resident R290's March 2025 Medication Administration revealed Resident R290 failed to receive the one liter of 5-0.45% Dextrose-Sodium Chloride as ordered. It was documented midline not yet placed, unable to give.</p> <p>Review of Resident R290's physician order dated 3/17/25, indicated to administer two liters of Dextrose 5% in Water (D5W-IV solution used to replace lost fluids and provide carbohydrates to the body) at 100 ml/hr for acute kidney injury and hypernatremia. It was indicated to start the IV fluids at 12:00 p.m.</p> <p>Review of Resident R290's March 2025 Medication Administration Record revealed the IV fluids ordered on 3/17/25, at 12:00 p.m. was left blank and not signed off for completion.</p> <p>Review of Resident R290's progress note dated 3/17/25, at 9:32 p.m. indicated a mid line was inserted into the resident's right cephalic vein and D5W was infusing at 100 ml/hr. The facility failed to timely administer parenteral fluids as ordered.</p> <p>During an interview on 3/20/25, at 11:26 a.m. the Nursing Home Administrator confirmed the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one of three residents (R290).</p> <p>During an interview on 3/20/25, at 2:25 p.m. Medical Doctor, Employee E39 stated he was under the assumption Resident R290 was provided all the IV fluids as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 3/21/25, at 9:48 a.m. Licensed Practical Nurse, Employee E38 indicated the facility uses an outside provider to insert midline and central lines. It was indicated they are available anytime to obtain a midline. An observation of the third floor nursing station revealed a phone number listed on the wall to call for central and midline IV insertions.</p> <p>28 Pa. Code: 201.14(a)(c) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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  03/21/2025
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.			
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</b></p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen and nebulizer management for four of four residents (Residents R15, R36, R80, and R84).</p> <p>Findings include:</p> <p>Review of the facility's Oxygen Concentrator policy dated 1/7/25, indicated nursing is responsible to change oxygen tubing and mask/nasal cannula (a thin tube that delivers oxygen into the nose) weekly, and as needed if it becomes soiled or contaminated. Change nebulizer tubing and delivery devices weekly. Keep delivery devices covered in plastic bags when not in use. Clean filters per manufacturer's recommendations.</p> <p>Review of the clinical record indicate Resident R15 was admitted to the facility on [DATE].</p> <p>Review of Resident R15's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 2/28/25, indicated diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and chronic obstruction pulmonary disease (COPD- difficulty in breathing).</p> <p>Review of Resident R15's physician orders dated 2/4/24, indicate oxygen at 2 liters per minute (LPM) via nasal cannula continuously every shift.</p> <p>Review of physician orders dated 9/3/24, indicate oxygen per orders, change tubing and filter weekly every night shift every Tuesday for care.</p> <p>Review of Resident R15's physician orders dated 2/14/25, indicated Ipratropium Albuterol Solution 0.5-2.5 (3) milligram (MG) 3 milliliters (ML) 3 ml inhaled orally every 4 hours as needed for shortness of breath (SOB) or wheezing via nebulizer (converts liquid medication into a fine mist).</p> <p>Review of Resident R15's physician orders dated 8/6/24, indicated nebulizer maintenance change equipment every week and as needed every night shift every Tuesday.</p> <p>During an observation on 3/17/25, at a 11:36 a.m. Resident R15 was in bed her oxygen was on via nasal cannula the oxygen tubing failed to be labeled with a date. A nebulizer machine was observed sitting on the windowsill the nebulizer failed to be labeled with a date and to be stored in a bag.</p> <p>During an interview completed on 3/17/25, at 11:41 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed Resident R15's oxygen tubing failed to be labeled with a date and the nebulizer failed to be labeled with a date and stored in a bag as required.</p> <p>Review of the admission record indicates Resident R36 was admitted to the facility on [DATE].</p> <p>Review of Resident R36's MDS dated [DATE], indicated the diagnoses of anemia (low iron in the blood), heart failure (heart can't pump as well as it should), and diabetes (high sugar in the blood).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R36's physician orders dated 2/3/25, indicated Ipratropium-Albuterol Solution 3 ml inhale via nebulizer three times a day for cough, bronchospasm for three days.</p> <p>During an observation on 3/19/25, at 10:29 a.m. a nebulizer was sitting on the dresser next to Resident R36, the nebulizer failed to be labeled with a name or date and failed to be stored in a bag.</p> <p>During an interview completed on 3/19/25, at 10:34 a.m. Registered Nurse (RN) Employee E35 confirmed the nebulizer was sitting on the dresser next to Resident R36's bed and failed to be labeled with a name or date or to be stored in a bag. RN Employee E35 was not able to clarify who it belonged to and stated Resident R36's nebulizer treatments were ordered for 3 days and were discontinued and removed the nebulizer machine from room.</p> <p>Review of the admission record indicated Resident R80 admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and high blood pressure.</p> <p>Review of Resident R80's physician order dated 2/24/25, indicated oxygen at 2 LPM via nasal cannula continuously.</p> <p>Review of Resident R80's current care plan failed to include oxygen administration or care and management of equipment.</p> <p>Observation on 3/17/25, at 9:36 a.m. Resident R80 was in the wheelchair in the hallway with an active nosebleed. Resident R80 was holding a tissue to his nose. The oxygen tubing for the nasal cannula was not dated as required.</p> <p>Interview on 3/17/25, at 9:40 a.m. Registered Nurse (RN) Employee E20 confirmed Resident R80's cannula was not dated as required.</p> <p>Review of Resident R84's admission record indicated she was originally admitted on [DATE].</p> <p>Review of Resident R84's physician orders dated 1/3/25, indicated to administer oxygen at three liters via nasal cannula continuously every shift.</p> <p>Review of Resident R84's MDS dated [DATE], indicated Resident R84's diagnoses included chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), pneumonia (an infection of the lungs caused by bacteria, virus, or fungi), Bacteremia (bacteria in the blood stream) and acute respiratory failure (a condition characterized by the lungs inability to exchange gases, leading to insufficient oxygen in the blood). The diagnoses were the most recent upon review.</p> <p>Review of Resident R84's MDS assessment dated [DATE], Section O-Specialized Treatments, Respiratory treatments 0110 C1- indicated an x meaning the use of oxygen for Resident R84.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R84's care plan dated 1/22/25, indicated to administer oxygen at three liters via nasal cannula continuously.</p> <p>During observations on 3/18/25, at 10:30 a.m. Resident R84 was observed in bed asleep. Her nasal cannula was observed on the floor and her oxygen concentrator was on.</p> <p>During observations on 3/18/25, at 10:48 a.m. Resident R84 was observed in bed asleep. Her nasal cannula was observed on the floor and her oxygen concentrator was on.</p> <p>During an interview on 3/18/25, at 10:51 a.m. Nurse aide (NA) Employee E11 stated: I don't think the Resident R84's oxygen cannula is on. I'll wipe it off and put it on her.</p> <p>During an interview on 3/18/25, at 1:18 p.m. information was disseminated to the Director of Nursing (DON) that the facility failed to provide appropriate respiratory care related to oxygen for Resident R84 as required.</p> <p>During an interview on 3/21/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide appropriate respiratory care related to oxygen and nebulizer management for four of four residents (Residents R15, R36, R80, and R84).</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of resident clinical records, facility policy and staff interview, it was determined the facility failed to provide care and services for the provision of hemodialysis (treatment that helps body remove extra fluid and waste products) consistent with professional standards of practice for one of two residents (Resident R80).</p> <p>Findings include:</p> <p>Review of the facility policy Hemodialysis dated 1/7/25, indicated the facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. The facility will coordinate and collaborate with the dialysis facility to assure that the resident's needs related to dialysis treatments are met. Documentation requirements are met to assure that treatments are provided as ordered by the physician.</p> <p>Review of the admission record indicated Resident R80 admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/28/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and high blood pressure.</p> <p>Review of Resident R80's physician order dated 2/24/25, indicated dialysis every Monday, Wednesday, and Friday.</p> <p>Review of Resident R80's current care plan indicated resident requires hemodialysis related to renal failure. Encourage resident to go for scheduled dialysis appointments.</p> <p>Observation on 3/17/25, at 9:36 a.m. Resident R80 was in the wheelchair in the hallway.</p> <p>Interview with Nurse Aide (NA) Employee E33 on 3/17/25, at 9:30 a.m. indicated Resident R80 missed his ride because he wasn't up on time.</p> <p>Interview on 3/17/25, at 9:40 a.m. Registered Nurse (RN) Employee E20 confirmed Resident R80 missed his transportation to dialysis today and that medic rescue could not come to transport him today. Resident will not go to dialysis until Wednesday now.</p> <p>Interview on 3/20/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide care and services for the provision of hemodialysis consistent with professional standards of practice for one of two residents (Resident R80).</p> <p>28 Pa. Code: S211.10(c) Resident care policies.</p> <p>28 Pa. Code: S211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of facility policy, resident observations, and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for three of five days (3/10/25, 3/17/25, and 3/18/25).</p> <p>Findings Include:</p> <p>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.</p> <p>Review of the admission record indicated Resident R80 admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/28/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and high blood pressure.</p> <p>Review of Resident R80's physician order dated 2/24/25, indicated dialysis every Monday, Wednesday, and Friday.</p> <p>Review of Resident R80's current care plan indicated resident requires hemodialysis related to renal failure. Encourage resident to go for scheduled dialysis appointments.</p> <p>Observation on 3/17/25, at 9:26 a.m. Resident R80 was in the wheelchair in the hallway.</p> <p>Interview with Nurse Aide (NA) Employee E33 on 3/17/25, at 9:30 a.m. indicated Resident R80 missed his ride because he wasn't up on time. NA Employee E33 indicated he was agency, this was his first day, and he passed the breakfast trays. It was only himself and one other nurse aide to start the daylight shift this morning. We have like 45 residents on the floor.</p> <p>Interview on 3/17/25, at 9:40 a.m. Registered Nurse (RN) Employee E20 confirmed Resident R80 missed his transportation to dialysis today and that medic rescue could not come to transport him today. RN Employee E20 indicated they started the shift with only two aides this morning and NA Employee E33 thought it more important that the residents get their breakfast trays passed and did not get Resident R80 out of bed in time for his transportation because he was still passing trays.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident R289 was admitted to the facility on [DATE], with the diagnoses of heart failure (heart doesn't pump blood as well as it should), UTI (urinary tract infection), non-Alzheimer's Dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), depression, and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Review of Resident R289's MDS dated [DATE], indicated the diagnoses remained current.</p> <p>Review of Resident R289's progress note dated 3/10/25, at 5:30 p.m. indicated nurse was alerted by Physical Therapist (PT) Employee E4 that resident had fallen down emergency exit steps. She was assessed and assisted into her wheelchair and carried up ten stairs with maximum assistance. Orders received and implemented to send her to the emergency room (ER) for further evaluation.</p> <p>Telephonic interview on 3/17/25, at 2:28 p.m. RN Employee E8 indicated I was passing my meds as RN Supervisor, on 3/10/25, I did text the Assistant Director of Nursing (ADON) Employee E9 because one of the aides expressed concern for Resident R289 needing a wander guard. Before I knew it, she was at the bottom of the steps, maybe within ten minutes of me texting the ADON. It's hard to be Supervisor and have a medication cart at the same time.</p> <p>Observation on 3/18/25, at 9:44 a.m. indicated RN Employee E8 was in hallway working with a medication cart.</p> <p>Interview on 3/18/25, at 9:44 a.m. RN Employee E8 indicated, That I know of nobody stayed with Resident R289 when I was trying to get the wanderguard information from the ADON. They were passing trays and I'm pretty sure there were only three aides that night. I was on the medication cart that night and Supervisor of the facility at the same time, as always, as I am again today.</p> <p>Interview on 3/18/25, at 9:42 a.m. Nurse Aide (NA) Employee E6 indicated at on 3/10/25, at 5:20 p.m. she was passing trays and noticed Resident R289 was not by the nurse's station where she was a few minutes prior. There were three aides. We all three work together, it's not enough help to get to everything. Resident R289 said she wanted to go home. She's said that since she got here. You can't watch them, if they are determined to get out, they're going to do it. I was picking up a second cart to pass trays, Resident 289 said she wanted to go home, and I responded let's eat dinner first and then we'll talk about it. When I got back, she was gone. I did not stay with the resident or tell the nurse because she wasn't in the hallway, then I'd have to go looking for her which would take me how long. During tray pass with only three aides, there's just no time to waste.</p> <p>Interview on 3/18/25, at 11:31 a.m. NA Employee E7 indicated there were three aides on 3/10/25, for evening shift, and recalled that the RN supervisor was on the medication cart and House Supervisor. It's not enough staff for the type of residents they've been bringing in here. The residents are more confused. Trays take a long time to pass because the aides have to put all the drinks on the trays individually.</p> <p>Interview with the Nursing Home Administrator on 3/18/25, at 10:57 a.m. confirmed the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for three of five days (3/10/25, 3/17/25, and 3/18/25).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 201.19(7) Personnel policies and procedures.</p> <p>28 Pa. Code 201.20(a) Staff development.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one of six residents reviewed (Resident R30).</p> <p>Findings include:</p> <p>Review of the facility Dementia Care policy last reviewed 1/7/25, indicated it is the policy of the facility to provide the appropriate treatment and services to every resident who displays signs of or is diagnosed with dementia, to meet his or her highest practicable, physical, and psychosocial well-being.</p> <p>Review of the facility policy Incidents and Accidents last reviewed 1/7/25, indicated the facility staff will report, investigate, and review any accidents or incidents that occur on facility property and may involve a resident. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root cause. Incidents that require an incident report include observed accidents/incidents, choking, and self-inflicted and unobserved injuries. The supervisor will be notified of the incident, and the nurse will contact the resident's practitioner to inform them of the incident, report any injuries, and obtain orders, if indicated. The nurse will enter the incident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. Documentation should include the date, time, nature of incident, location, initial findings, immediate interventions and will document all pertinent information.</p> <p>Review of Resident R30's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 1/28/25, indicated diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition), dementia (the loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.), and eating disorder.</p> <p>Review of Resident R30's care plan dated 9/1/22, revised 2/28/23, indicated the resident has an alteration in cognition due to dementia. Interventions included to anticipate the resident's needs to the extent as possible.</p> <p>Review of Resident R30's care plan dated 2/29/24, indicated the resident exhibits behaviors symptoms such as wandering the unit and in and out of resident rooms, placing items in mouth, due to dementia, cognitive impairment, and PICA (an eating disorder where a person compulsively eats things that aren ' t food and don ' t have any nutritional value or purpose). Interventions included to praise and reinforce while gently redirecting out of other rooms, notify physician of negative behavior or activity.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R30's progress note dated 2/28/25, at 5:10 p.m. indicated the resident was found in the sun room. Resident R30 took a bite out of a gold glitter Styrofoam coin. Resident still had pieces of Styrofoam in her mouth. Resident would not allow nurse to attempt to remove them. Gave resident three spoonful's of pudding o allow resident to swallow without choking on pieces.</p> <p>Review of Resident R30's late entry progress note dated entered by the Director of Nursing on 3/12/25, at 1:05 p.m. indicated the resident's family and provider was notified of incident on 2/28/25. It was indicated social services is working with family to provide possible placement to a controlled environment due to diagnosis and behaviors. The facility failed to timely document a physician was notified, obtain orders, and document immediate interventions implemented for Resident R30 after ingesting a foreign object on 2/28/25.</p> <p>Review of the facility list of incidents on 3/19/25, at 1:34 p.m. failed to include Resident R30's incident of ingesting a foreign body.</p> <p>During an interview on 3/20/25, at 9:33 a.m. the Nursing Home Administrator confirmed the facility failed to ensure a resident with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one of six residents reviewed (Resident R30).</p> <p>28 Pa. Code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based upon clinical record review, and staff interview, it was determined that the facility failed to ensure that any irregularities submitted in the medication regimen reviews (MRR) by pharmacy were acted upon for one out of five residents (Resident R30).</p> <p>Findings include:</p> <p>Review of the facility Use of Psychotropic Medication(s) policy dated 8/21/24, indicated it is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. A psychotropic drug is any drug that affects brain activities associated with mental processes and behaviors. Psychotropic drugs include, but are not limited to the antipsychotics, antidepressants, anti-anxiety, and hypnotics. Residents who use psychotropic drugs shall receive gradual dose reductions, unless contraindicated, in an effort to discontinue these drugs. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as during the pharmacist's monthly medication regimen review.</p> <p>Review of Resident R30's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 1/28/25, indicated diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition), dementia (the loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.), and anxiety.</p> <p>Review of Resident R30's care plan dated 9/1/22, revised 7/19/23, indicated the resident has a potential for adverse reactions from ongoing use of psychotropic medications. Attempt gradual dose reduction as indicated unless previous attempts have failed and or is contraindicated due to medical condition. Identify potential side effects of the medications and monitor for/document changes in clinical appearances (increased falls). Notify physician as needed for further interventions. Obtain labs as ordered and notify physician of results for further interventions. Consult psychiatric services as indicated.</p> <p>(continued on next page)</p>		

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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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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R30's pharmacy medication regimen review dated 1/7/25, indicated pharmacy recommendations from October 2024 were still not responded to. It was indicated the resident has had several recent falls, which may have been aggravated by the following medication(s): Seroquel 25mg/50mg, Ativan 1 mg, trazadone 25 mg, and her low diastolic blood pressure. Fluvoxamine and trazadone may lead to SIADH (Syndrome of Inappropriate Antidiuretic Hormone Secretion occurs when the bod makes excess amounts of antidiuretic hormone (ADH).), which can cause imbalance problems that may lead to falls as well as low blood pressure. It was indicated to please consider lab order to determine if this may be a problem for this resident. The resident's diastolic blood pressure has been low 58 and 64 for example. It was indicated Fluvoxamine 100mg and Trazadone 25mg were due for a gradual dose reduction (GDR) and to consider having a psychiatric services re-evaluate the resident for a possible GDR. After physician was reviewed, please place in Resident's Chart. The facility failed to obtain a physician response.</p> <p>During an interview on 3/21/25 09:24 a.m. the Nursing Home Administrator confirmed the facility failed ensure the attending physician reviewed the pharmacist's identified irregularities and failed to document the action taken or not taken to address the irregularities for one of four residents (Resident R30).</p> <p>28 Pa. Code: 201.14(a)(c) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.5(f)(i)-(xi) Medical records.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in three of six medications carts (Grandview medication cart, Riverside medication cart and Rosewood medication cart) and failed to properly secure treatment medication in one of four treatment carts (Fourth floor Rosewood hall treatment cart) and failed to secure one of two medication rooms (fourth floor medication room).</p> <p>Findings include:</p> <p>Review of the facility policy Medication Storage in the Facility last reviewed 8/1/24, indicated medications and biologicals are stored safely, securely, and properly, following manufactures recommendations or those of the supplier.</p> <p>During an observation on 3/17/25, at 9:55 a.m. the treatment cart was in the Riverview hallway next to room [ROOM NUMBER] unsecured, unattended and accessible to any passerby.</p> <p>During an observation on 3/17/25, at 11:18 a.m. the treatment cart was in the Riverview hallway next to room [ROOM NUMBER] unsecured, unattended and accessible to any passerby.</p> <p>During an interview completed on 3/17/25, at 11:21 a.m. Nurse Aid Employee E27 confirmed the treatment cart was unsecured, unattended and accessible to any passerby. Nurse Aid Employee E27 then walked over to the treatment cart and locked it.</p> <p>During an observation on 3/17/25, at 11:56 a.m. the fourth floor medication room was open and without a secure lock on the door and accessible to any passerby.</p> <p>During an interview on 3/17/25, at 12:00 p.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the fourth-floor medication room was open and without a secure lock on the door, accessible to any passerby and that the facility failed to secure medications on the Fourth floor medication room as required.</p> <p>During an observation on 3/18/25, at 10:19 a.m. it was revealed that the Riverside medication cart contained:</p> <p>1 vial Lantus insulin belonging to R18 opened and without a date.</p> <p>1 box of lidocaine patches</p> <p>1 box fleet enema</p> <p>During an interview completed on 3/18/25, at 10:24 a.m. Registered Nurse (RN) Employee E2 confirmed the above observations.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 3/19/25, at 9:08 a.m. it was revealed that the Grandview Medication Cart contained:</p> <ul style="list-style-type: none"> <li>1 foley catheter insertion tray</li> <li>1 bottle liquid protein no date opened</li> <li>1 bottle liquid Haldol belonging to Resident R35 no date opened</li> <li>1 bottle refresh tears belonging to Resident R88 no date opened</li> <li>1 box lemonade packet</li> <li>1 box pomegranate lemonade packet</li> <li>1 vial Lantus belonging to R66 no date opened as well as art tears no date opened</li> <li>1 box lidocaine patches</li> <li>1 medication pill planner with four colored sections, two sections the yellow and purple were filled with medications no resident name, date, or identification of medications.</li> <li>1 bottle of ginger ale that was opened.</li> </ul> <p>During an interview completed on 3/19/25, at 9:22 a.m. Licensed Practical Nurse (LPN) Employee E37 confirmed the above observations and stated the ginger ale was hers.</p> <p>During an observation on 3/19/25, at 9:31 a.m. it was revealed that the Rosewood medication cart contained:</p> <ul style="list-style-type: none"> <li>1 box lidocaine patches</li> <li>1 package goldfish crackers</li> </ul> <p>During an interview completed on 3/19/25, at 9:36 a.m. LPN Employee E38 confirmed the that the facility failed to store medications and biologicals properly and securely as required.</p> <p>28 Pa. Code: 211.9(a)(1)(L)(1) Pharmacy services.</p> <p>28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on clinical record review and staff interview it was determined the facility failed to obtain laboratory services as ordered for one of two residents (Resident R290).</p> <p>Findings Include:</p> <p>A review of the facility Laboratory Services and Reporting reviewed 1/7/25, indicated the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The facility must provide or obtain laboratory to meet the needs of its residents. The facility is responsible for the timeliness of the service.</p> <p>A review of the facility Provision of Physician Ordered Services last reviewed 1/7/25, indicated the facility will provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. The facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician orders.</p> <p>Review of the clinical record revealed that Resident R290 was admitted to the facility on [DATE], with diagnoses of high blood pressure, depression, and non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities.)</p> <p>Review of Resident R290's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 3/9/25, indicated diagnoses were current.</p> <p>Review of Resident R290's physician orders indicated to obtain a CMP (Comprehensive Metabolic Panel a series of 14 blood tests. It gives your doctor a snapshot of how your liver and kidneys are working, your blood sugar (glucose) level, and your electrolyte and fluid balance.) and CBC (Complete Blood Count complete blood count (CBC) is a blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets.) on 3/17/25, one time only for hypernatremia.</p> <p>Review of a progress note dated 3/17/25, stated per lab tech, labs were obtained on 3/14/25.</p> <p>Review of Resident R290's clinical record failed to include evidence Resident R290's lab work was obtained as ordered on 3/17/25.</p> <p>Review of Certified Registered Nurse Practitioner, Employee E40 follow-up note dated 3/19/25, indicated Resident R290 was to have labs drawn on 3/17/25, but they were not completed. A new order was entered to have labs drawn on 3/19/25.</p> <p>Review of Resident R290's physician order dated 3/19/25, indicated to obtain a CMP, CBC with differential for acute kidney injury, hypernatremia, and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). It was indicated facility staff must draw.</p> <p>(continued on next page)</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R290's clinical record failed to include evidence Resident R290's lab work was obtained as ordered on 3/19/25, by facility staff.</p> <p>During an interview on 3/20/25, at 11:26 a.m. the Nursing Home Administrator confirmed the facility failed to obtain Resident R290's lab work as ordered.</p> <p>During an interview on 3/20/25, at 2:25 p.m. Medical Doctor, Employee E39 stated he was under the assumption Resident R290 labs were obtained by staff on 3/19/25, as ordered.</p> <p>28 Pa. Code: 201.14(a)(c) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45577</p> <p>Based on a review of facility policy, observation, and staff interview, it was determined that the facility failed to properly maintain kitchen equipment and one unit pantry in a sanitary condition creating the potential for cross contamination and food-borne illness (Main Kitchen and 3rd floor).</p> <p>Findings include:</p> <p>A review of facility policy Sanitation Inspection, dated 1/7/25, indicated that it is the policy of the facility to ensure food service areas are clean, sanitary, and in compliance with applicable state and federal regulations.</p> <p>During an observation on 3/17/25, at 10:03 a.m., a tour of the walk-in cooler in the main kitchen conducted with Food Services Director (FSD) Employee E16, revealed that the cold air condenser fan covers (2 total) and the ceiling immediately forward of these cooler fans had a build-up of dust, grime, and debris. FSD Employee E16 confirmed observation by surveyor when viewed.</p> <p>During an interview on 3/17/25, at 10:05 a.m., FSD Employee E16 confirmed that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination and food-borne illness in the main kitchen.</p> <p>During an observation on 3/20/25, at 2:03 p.m., of the 3rd floor unit pantry freezer, conducted with FSD Employee E16, revealed the following:</p> <ul style="list-style-type: none"> <li>- 3 non-food ice packs, a silicon ice tray, a silicon ice bag were being stored in freezer</li> <li>- multiple opened half-consumed unlabeled undated frozen bottled beverages (water bottle, Gatorade bottle)</li> <li>- multiple opened half-consumed undated ice cream novelties (3)</li> </ul> <p>During an interview on 3/20/25, at 2:04 p.m., FSD Employee E16 confirmed observations of 3rd floor unit pantry freezer, and confirmed that the facility failed to properly maintain unit pantry freezer in a sanitary condition creating a potential for cross contamination and food-borne illness on one of two nursing units.</p> <p>During an interview on 3/21/25, at 2:45 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to properly maintain kitchen equipment and one unit pantry in a sanitary condition creating the potential for cross contamination and food-borne illness (Main Kitchen and 3rd floor).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for two of three residents (Resident R15 and R30).</p> <p>Findings include:</p> <p>Review of the facility policy Coordination of Hospice Services dated 8/21/24, last reviewed 1/7/25, indicate when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident ' s highest practicable physical, mental, and psychosocial well-being. Guidelines include but not inclusive to:</p> <ol style="list-style-type: none"> <li>1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.</li> <li>2. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility.</li> <li>3. The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities.</li> <li>4. The facility will monitor for medications and medical supplies to ensure they are provided by hospice as indicated in the plan of care for palliation and management of the terminal illness.</li> </ol> <p>Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE].</p> <p>Review of Resident R15's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 2/28/25, indicated diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and chronic obstruction pulmonary disease (COPD- difficulty in breathing). Section O-0110 Special treatments indicated an x for hospice services.</p> <p>Review of Resident R15's physician orders dated 6/26/24, indicates a hospice evaluation.</p> <p>Review of Resident R15's physician orders dated 6/27/24, indicate hospice initiated for the diagnosis of COPD.</p> <p>Review of Resident R15's clinical record failed to include a written agreement with the hospice provider that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R15's clinical record failed to maintain communication with hospice as it relates to the residents' plan of care and services to ensure each entity is aware of their responsibilities.</p> <p>Review of Resident R15's hospice binder on 3/20/25, at 10:09 a.m. indicated faxed hospice notes for the months of 8/24, and 9/24.</p> <p>During an interview completed on 3/20/25, at 10:06 a.m. upon asking Registered Nurse Employee E25 concerning Resident R15's hospice binder and recent hospice services received he stated, I haven't seen anyone here from this hospice since I have been here, I'm only here 3 days a week and I just started on 2/21/25.</p> <p>During an interview completed on 3/20/25, at 10:18 a.m. Medical Record Director Employee E24 confirmed that there was not a current hospice binder for Resident R15 and stated, all information we have for her is faxed over, the other agencies have the documentation in their binders I don't see anything current in hers.</p> <p>During an interview completed on 3/20/25, at 1:00 p.m. the [NAME] President of Clinical Operations Employee E26 confirmed that no hospice contract was available for Resident R15's chosen hospice provider and the hospice binder was not kept up to date and that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R15).</p> <p>Review of Resident R30's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R30's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 1/28/25, indicated diagnoses Alzheimer's Disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition), dementia (the loss of cognitive functioning-thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.), and anxiety.</p> <p>Review of Resident R30's care plan dated 2/29/24, indicated the resident exhibits behaviors symptoms such as wandering the unit and in and out of resident rooms, placing items in mouth, due to dementia, cognitive impairment, and PICA. Interventions included to administer psychotropic medications as ordered.</p> <p>Review of Resident R30's physician order dated 4/18/24, indicated to administer 25 milligram (mg) of Seroquel one time a day for dementia with psychotic disturbance.</p> <p>Review of Resident R30's care plan dated 6/11/24, indicated the resident is on hospice with a diagnoses of Alzheimer's Disease with behaviors of wandering. It was indicated to administer antianxiety medications per orders, assess and documented effectiveness, and to notify the physician and hospice if not effective.</p> <p>Review of Resident R30's physician order dated 6/11/24, indicated to admit to hospice.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R30's recommendations from Hospice dated 1/22/25, indicated to discontinue Seroquel and order Zyprexa 5 mg one tablet in the morning and 10 mg, two tablets at bedtime to help control behaviors of PICA.</p> <p>Review of Resident R30's progress note dated 2/28/25, at 5:10 p.m. indicated the resident was found in the sun room. Resident R30 took a bite out of a gold glitter Styrofoam coin. Resident still had pieces of Styrofoam in her mouth. Resident would not allow nurse to attempt to remove them. Gave resident three spoonful's of pudding o allow resident to swallow without choking on pieces.</p> <p>Review of Resident R30's clinical record on 3/20/25, at 10:04 a.m. revealed Resident R30's Seroquel was discontinued as ordered by hospice on 1/22/25. Review of Resident R30's clinical record failed to include an order for Zyprexa to help control Resident R30's behaviors of PICA.</p> <p>During an interview on 3/20/25, at 1:26 p.m. Registered Nurse (RN) Employee E41 confirmed Resident R30 was never ordered Zyprexa to help control her behaviors of PICA.</p> <p>During an interview on 3/20/25, at 1:42 p.m. the Nursing Home Administrator confirmed the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of three residents (Resident R15, R30, and R37).</p> <p>28 Pa. Code: 201.14(a) Responsibilities of licensee.</p> <p>28 Pa. Code: 201.18(b)(1)(3) Management.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>35785</p> <p>Based on review of the facility's policy, plan of correction for previous incident, resident records and staff interview it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and make certain that plans to improve the delivery of care and services effectively addressed concerns identified during an elopement (2/6/25).</p> <p>Findings include:</p> <p>The facility Quality assessment and assurance committee policy last reviewed on 1/7/25, indicated that the facility will maintain a QA committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies.</p> <p>Review of the facility policy Elopements and Wandering Residents dated 1/7/25, indicated that the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>Review of Resident R79's progress note dated 2/6/25, at 5:01 p.m. indicated the staff heard alarm sounding on the 4th floor at 3:05 p.m. and the resident was observed off the unit on the emergency stairwell, staff assisted the resident back to the unit.</p> <p>Review of Quality assurance meeting documentation on 2/6/25, indicated that the QA committee met on 2/6/25 and put correct concerns in place to prevent future elopements down the emergency stairway.</p> <p>Review of R289's clinical progress notes indicated that on 3/10/25, at 5:30 p.m. staff was alerted by Physical Therapist (PT) Employee E4 that Resident R289 had eloped and fallen down emergency exit steps.</p> <p>The incident on 3/10/25 was the second elopement in an emergency stairway by a resident.</p> <p>During an interview on 3/21/25, at 12:21 p.m. the Nursing Home Administrator (NHA) information was disseminated that the facility failed to correct quality deficiencies and make certain that plans to improve the delivery of care and services effectively addressed concerns identified during an elopement on 2/6/25.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p>		

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  03/21/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46336</p> <p>Based on review of facility policies, documentation, observations, resident and staff interviews and state and federal guidance it was determined that the facility failed to fully implement COVID monitoring, tracking, and testing in accordance with state and federal guidance for outbreak response, placing residents at risk for potentially acquiring communicable disease, failed to follow enhanced barrier precautions for one of three residents reviewed (Residents R51), and failed to prevent cross contamination during a medication pass for one of three residents (Resident R88).</p> <p>Findings include:</p> <p>Review of the facility policy Infection Prevention and Control Program dated 1/7/25, indicated the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines, to include a system of surveillance. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current Centers for Disease Control and Prevention (CDC) guidelines.</p> <p>Review of the Pennsylvania Department of Health COVID-19 Infection Control and Outbreak Response Toolkit for Long-Term Care Version 1.1 dated February 2024, and expanded from infection prevention and control guidance from the Centers for Disease Control and Prevention (CDC) for nursing homes and Long-Term Care Facilities indicated the following:</p> <p>During the Outbreak: COVID-19 Outbreak Management and Control Measures included:</p> <ul style="list-style-type: none"> <li>-Identify and Isolate First Case.</li> <li>-Identify Additional Cases and Exposures.</li> <li>-Exposed asymptomatic residents and HCP (health care professional) should be tested with a series of up to three viral tests.</li> <li>-Determine approach (contact-tracing, unit-based, facility-based).</li> <li>-Identify exposures because of close contact.</li> <li>-Test exposures immediately (but not within 24 hours of exposure) and if negative, another test at 48 hours, and if negative another test 48 hours later.</li> <li>-Returning to Routine Operations</li> <li>-The facility can return to routine operations when the outbreak has been deemed as complete, which occurs after 14 days without new cases.</li> <li>-Evaluation and Monitoring of Residents</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-It is important to assess for the following symptoms and implement prompt isolation and further evaluation for COVID</p> <p>Fever or chills</p> <p>Cough</p> <p>Shortness of breath</p> <p>Fatigue</p> <p>Muscle or body aches</p> <p>Headache</p> <p>New loss of taste or smell</p> <p>Sore throat</p> <p>Congestion or runny nose</p> <p>Nausea or vomiting</p> <p>Diarrhea</p> <p>Review of resident clinical records and facility documents revealed:</p> <p>Review of facility submitted report dated 3/19/25, indicated Registered Nurse (RN) Employee E20 tested positive for COVID on 3/19/25. Staff member tested positive before the start of the shift via rapid test. It was indicated as a follow-up action, the facility tested residents on 3/19/25, with no positive residents at that time. Will monitor for any changes in condition.</p> <p>Review of the facility's COVID tracking log indicated tracking of resident positives from January and February 2025. The facility failed to accurately track testing of the residents. The tracking failed to indicate a log that included resident's name, date, and outcome of test whether it was positive or negative.</p> <p>Interview on 3/20/25, at 10:10 a.m. the Nursing Home Administrator indicated she thought a new outbreak was two or more. Confirmed there was not signage of the outbreak at the front entrance to alert visitors, residents, and staff.</p> <p>Review of the clinical record indicated Resident R30 admitted to the facility on [DATE].</p> <p>Review of Resident R30's progress notes indicated Covid testing was completed on the following dates: 1/20/25, 1/23/25, 1/30/25, 2/6/25, and 2/10/25.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 3/19/25, at 11:00 a.m. RN Employee E23 was Covid swabbing all the residents in the facility.</p> <p>Interview on 3/20/25, at 10:15 a.m. RN Employee E23 indicated we've been testing weekly for a while. We tested everyone yesterday because a staff member was positive yesterday. RN indicated she tested the entire facility for covid, and no residents were positive at that time.</p> <p>Interview with Nursing Home Administrator and RN Employee E23 on 3/20/25, at 10:30 a.m. revealed the facility was unaware of CDC guidance to test exposures immediately (but not within 24 hours of exposure) and if negative, another test at 48 hours, and if negative another test 48 hours later (days 1, 3, and 5). Confirmed the testing was completed incorrectly on day zero (3/19/25) and that only residents that were identified through contact tracing of RN Employee E20 were required to be tested for possible exposure, unless otherwise symptomatic. Interview further confirmed there were no orders entered for the facility's residents to be monitored daily for new signs and symptoms of respiratory illness.</p> <p>The facility was unable to provide Contact Tracing for RN Employee E20's positive covid test.</p> <p>Interview on 3/20/25, at 10: 30 a.m. the Nursing Home Administrator and RN Employee E23 confirmed the facility failed to accurately track, test, and monitor resident's during the new COVID outbreak that started on 3/19/25.</p> <p>Review of the facility policy Enhanced Barrier Precautions last reviewed 1/7/25, indicated it is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, peripherally inserted central line (PICC) lines, midline catheters) even if the resident is not known to be infected or colonized with a multi drug resistant organism (MDRO), peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk</p> <p>Review of the facility policy Hand Hygiene last reviewed 1/7/25, indicates all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.</p> <p>Review of the admission record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/25/25, indicated the diagnoses of hypertension (high blood pressure), neurogenic bladder (loss of bladder control), and benign prostatic hyperplasia (BPH- enlargement of the prostate gland).</p> <p>Review of Resident R51's physician orders dated 1/15/25, indicates 16 French 10 cubic centimeters (cc) balloon foley catheter for neurogenic bladder.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Resident R51's physician orders dated 1/14/25, indicate enhanced barrier precautions (EBP) related to (r/t) Foley catheter every shift.</p> <p>Observation on 3/17/25, at 10:01 a.m. indicated Resident R51 was in bed with a foley catheter. Observation of the door failed to have signage indicating EBP.</p> <p>Interview and observation on 3/17/25, at 10:39 a.m. Licensed Practical Nurse Employee E3 confirmed that Resident R51 did not have signage for EBP.</p> <p>During a medication pass observation completed on 3/18/25, at 9:00 a.m. Licensed Practical Nurse (LPN) Employee E1 administered Resident R84's medication, exited the room while coughing into her hands and entered Resident R88's room and shut of her nebulizer treatment.</p> <p>During an interview completed on 3/18/25, at 10:13 a.m. LPN Employee E1 confirmed administration of Resident R84's medication, exiting the room while coughing into her hands and entering Resident R88's room to shut off her nebulizer treatment without completing hand hygiene.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on 3/21/25, at 2:30 p.m. confirmed the facility failed to fully implement COVID monitoring, tracking, and testing in accordance with state and federal guidance for outbreak response, placing residents at risk for potentially acquiring communicable disease, failed to follow enhanced barrier precautions for one of three residents reviewed (Residents R51), and failed to prevent cross contamination during a medication pass for one of three residents (Resident R88).</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		