

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 174 Virginia Avenue Rochester, PA 15074	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision for one resident resulting in elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge). This failure created an immediate jeopardy situation for one of seventeen residents (Resident R77) identified as having a high risk for wandering. Findings include: Review of the facility policy Elopements and Wandering Residents last reviewed 12/11/25, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-entered plan of care addressing the unique factors contributing to wandering or elopement risk. Adequate supervision will be provided to help prevent accidents or elopements. Post-elopement: A nurse will perform a physical assessment, document and report findings to physician. Any new physician orders will be implemented and communicated to the family/authorized representative. A social service designee will reassess the resident and make referrals for counseling or psychological/psychiatric consults. The resident and family/authorize representatives will be included in the plan of care. Staff may be educated on the reason for elopement and possible strategies for avoiding behavior. When repeated elopements attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. Document in the medical record will include findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. Review of the facilities Elopement Log Events Quick Reference Guide worksheet indicated: To be completed at time of occurrence: Time of first reported missing. Time of notify executive director, director of nursing, and other staff in building. Time of overhead paging Mr., Mrs., Ms., residents name, please return to your room repeated three times. Time of all rooms checked (including bathrooms, closets, offices etc.). Time of the outside perimeter check of the building and property. Time of coordination of emergency team for vehicle and foot search. Go out in pairs and set specific check in times utilizing cell phones if available. Time of Contacting the police. Give them elopement risk identification form, with current photo, time and location when last seen, and an accurate description of what resident was wearing. Time of notification residents responsible party, Question for possible locations resident may have gone, friends, other family members. Time of physician notification. Time of staff members knocking on door (neighborhood homes and businesses) within a 2-3 block radius. Time of assisting police department. Time of two staff searches of the resident's room, looking for wallet, shoes, and coat. Time of searching any place that the resident has a history of frequenting. Time of checking previous living arrangements. Time of calling motels, restaurants, and shopping malls within search area. Time of extending perimeter search. Time of notification to the nursing facility licensing unit per state guidelines. Time of search continued until resolution or until police/fire rescue instruct to cease. To be completed at time of return: Time returned to facility and obtained witness statements. Time completed head to toe exam and document results. Notify physicians of any identified issues. Time of (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	notification of all previous contacts. Time of documenting the factual account of the occurrence and complete an incident report. Time of updating the elopement risk evaluation form. Time placed on wander guard following the elopement/wandering policy. Time of review and update to care plan and Kardex - update interventions. Review of the facility policy Comprehensive Care Plans last reviewed 12/11/25, indicated it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a residents medical, nursing, mental and psychosocial need. Review of the admission record indicated Resident R77 was admitted to the facility on [DATE]. Review completed of Resident R77's physician orders dated 7/20/25, indicated wander guard system for safety elopement and exit seeking. Review Resident R77's care plan dated 7/20/25, indicated resident is at risk for elopement, but failed to identify any triggers that may cause the resident to be exit seeking. Review of clinical record revealed an Elopement evaluation dated 9/14/25, which revealed that Resident R77 had score of 25, indicating that resident was at risk for elopement. The clinical record failed to reveal any further elopement risk. Review of Resident R77's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/5/25, indicated the diagnoses of hypertension (high blood pressure), depression, and hyperlipidemia. Section C0500 the Brief Interview for Mental Status indicated a score of five - severe impairment. Review of a written statement dated 1/31/26, Licensed Practical Nurse (LPN) Employee E2 indicated I was going to get on the elevator to leave, as the elevator door opened, the girl from personal care unit was standing there. She asked me if we were missing someone. I said not that I know of. She told me about Resident R77. I then told the other two nurses LPN Employee E34 and LPN Employee E35 and they went down to get him. The last time we visualized him me and LPN Employee E35 were at the lilac medication cart about to count narcotics. Resident R77 came to the side of the cart and then he was redirected. I never heard any alarm. That doesn't necessarily mean it didn't go off. There were a couple of instances during the shift that he was exit seeking a little that day. I did put a progress note. We re-directed him because of this. He is usually with me. I wouldn't of thought to check the stairwells if the alarm did sound but I personally did not hear one. Review of a written statement provided by the Personal Care Employee (PCU) Employee E33 dated 2/1/26, scratched off and re-dated 1/31/26, indicated I just got done giving a shower, I was putting linens in a bin, and I heard a bell go off, I saw on the wall where it said back door. I walked back and PCU Employee E32 followed. We are walking back and I saw a gentleman, and I said hey buddy are you ok? He said no, I asked if he wanted a cup of tea, so I gave him some. Then I went up to the girls on the third floor. It was between 6:30 p.m. to 7:00 p.m. I think he came through the stairwell, but we can't confirm. When I went upstairs, the ladies' upstairs were complaining about the alarms going off. I said I don't know about that I am just returning him back. The resident was very pleasant and fine. Pleasantly confused. Review of a written statement provided by the PCU Employee E32 dated 1/31/26, indicated I heard the back door alarm inside of the personal care facility and went to go look. Me and another personal care employee saw a manor resident who was in the back hall asked if he was ok. We redirected him to the dining room then brought him back up to the third floor. He was not injured and was pleasantly confused. I don't know if he came from the stairwell or the main door. We don't know which way he came from. I could have missed him, I can't say for sure. Review of a written facility provided statement dated 1/31/26, Licensed Practical Nurse (LPN) Employee E34 indicated I responded to the alarm to the back of the 370 hall. Then the stair alarm went off on the other side of the hall and I responded to them. This was around 7:00 p.m. I turned the alarm off, and I didn't see anyone around and then started answering call lights because those were also going off. The lady from the second floor told us Resident R77 was down there. Me and LPN Employee E35 went and got him. When we got him, he was fine. Review of Resident R77's nursing progress note dated 2/1/26, at 6:51 p.m. indicated resident has been exit seeking this shift. Redirection ineffective. Review of facility provided documentation of Resident R77's incident dated 2/1/26, at 7:00 p.m. indicated resident exhibiting more exit seeking behavior (continued on next page)		

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Resident reports going downstairs in his house, resident also reports nice people offering me tea, Resident denies any injuries, no pain, remains at baseline which is cognitively confused. Review of Resident R77's nursing progress note dated 2/1/26, at 9:30 p.m. indicated resident noted to have increased exit seeking behavior this day. New elopement risk evaluation completed. Wander guard evaluated for functionality and is working appropriately. Review of Resident R77's progress note date 2/2/26, at 11:27 a.m. indicated residents wander guard is intact. Resident was walked throughout unit (by staff) to ensure all doors/exits are alarming as they should if resident should try and exit unit. All alarms are audible and functioning. Resident is able to be redirected and is currently not exhibiting exit seeking behavior. Staff ensuring resident is visualized at all times on the unit. Will continue to monitor and ensure resident safety. Review of Resident R77's nursing progress note dated 2/2/26, at 3:33 p.m. indicated son of this resident called at this time and was inquiring about a missed call he received from facility. This nurse explained the elopement last night and son was understanding. Son asked many questions about his father's clinical condition and this nurse provided answers to the best of ability. Son was satisfied and thankful for the information. Further review of Resident R77's progress notes did not include any documentation about the resident leaving the floor. Review of Resident R77's progress notes dated 2/4/26, at 10:37 RN Employee E36 indicated episode clarified that this was a wandering incident. Resident never eloped from facility. Resident remained safe and unharmed throughout incident, and all follow up. During an observation completed on 2/9/26, at 11:48 a.m. Resident R77 was in the common area across from the third-floor nursing station. A nurse aid was next to him. Upon asking Licensed Practical Nurse (LPN) Employee E2 concerning the resident's behaviors stated Resident R77 is one on one supervision. The nurse aid just got here at 11:00 a.m. They called her in when they found out that the State Agency (SA) was here. He has a wander guard on. Last week the resident went out the back stairway down two flights of stairs into the personal care facility. Further interview with LPN employee E2 on 2/9/26, at 12:38 p.m. stated I came in at 7:00 a.m. I worked a 12-hour shift, about 10 min after 7:00 p.m. Resident R77 came to the cart I asked him to give me a minute we were doing the narcotic count. I did not see him after as my shift was over. I did not hear an alarm while I was here. When I went to get on the elevator to leave the girl from the personal care facility was in the elevator and asked if we were missing anyone, the girl stated Resident R77's first name. I gave the nurses the information. The girl from the villa said he was down having a cup of tea. LPN Employee E35 went down to get him. It must have been a very short time that he left the cart and went down the steps. I would 100 percent consider it an elopement. The Director of Nursing called me on the way home and asked me to tell her if it was an elopement, I told her yes 100 percent it was an elopement. There was no staff members with him just the girl from downstairs who redirected. During a telephonic interview completed on 2/9/26, at 2:45 p.m. Upon asking Registered Nurse (RN) Employee E36 concerning the discrepancies in the documentation and the date of event replied The incident report is dated 2/1/26, I was asked to put the report in and back date it to the first. I was not there when it happened. LPN Employee E2 was leaving at the end of her shift she would know the exact date. It was later in the evening around shift change; I was directed to complete the incident report by the Former Nursing Home Administrator Employee E31 and the [NAME] President of Clinical Operations Employee E7. Interview completed on 2/9/26, at 2:55 p.m. upon asking LPN Employee E2 concerning the date and time of the event she clarified it did happen on 2/1/26. Interview on 2/10/26, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 12:37 p.m. the [NAME] President of Operations Employee E7 confirmed the facility failed to provide adequate supervision for one of seventeen residents (Resident R77) resulting in elopement and were notified that Immediate Jeopardy was called due to the elopement of Resident R77 on 2/1/26. An Immediate Jeopardy template was issued to Nursing Home Administrated (NHA) and [NAME] President of Operations (VPO) Employee E7 and a corrective action plan was requested. On 2/10/26, at 4:21 p.m. an immediate action plan was received and accepted which included the following interventions: Immediate action: Resident was returned to his room by staff and assessed by RN. No injuries observed. Staff evaluated wander guard on residents and door alarm checks were conducted with no issues. provided resident redirection based on his likes and needs, provided beverages, placed on 15 min checks. 2/4 he was placed on 1:1. Resident was assessed by NP for change in medical condition and any labs needed and he is at baseline. Medication review conducted 2/9/26, with no orders. Elopement risk evaluation will be updated, and care plan updated to include resident preferences and any triggers for exit seeking behaviors. All residents will have updated elopement risk evaluations completed by DON or designee by 2/10/26. Care plan interventions for residents identified for elopement risk will be updated with specific person-centered triggers and interventions to ensure residents identified as elopement risk are not permitted to leave supervised areas unattended. This will be completed by DON or designee by 2/11/26. All residents who have been identified as an exit seeking risk will have wander guard care plans and orders to check function. Elopement Risk Binders were updated to ensure accuracy on 2/10/26. System Correction: All staff will be educated on recognizing exit seeking behaviors, door alarm response, supervision, elopement binder process and policies, and reporting exit seeking behavior. Licensed nurses will be educated on elopement risks and assessments, and care planning, exit seeking. This education includes agency staff, and staff will be educated prior to their next scheduled shift. This will be completed by the NHA or designee. Review and update the elopement policy as needed to ensure it includes. identification of residents who are at risk for eloping. Maintenance did conduct a door alarm check. Door alarm company will also be onsite to ensure all doors have appropriate sensitivity and for the wander guard to trigger the alarm, and that all alarms are functioning appropriately on 2/10/26. Monitoring: Audits of exit seeking behaviors and implementation of care plan interventions as needed, and door alarms/wander guard system will be conducted by DON or designee daily x 2 weeks, weekly x 4 weeks, then monthly x 3 months to ensure evaluations and care plans are up to date. Audits of assignment sheets to confirm R77's 1:1 supervision will be conducted by DON or designee daily x 2 weeks, weekly x 4 weeks, then monthly x 3 months. Elopement binders will be audited by NHA or designee daily x 2 weeks, weekly x 4 weeks, then monthly x 3 months. Findings of audits will include updated elopement evaluations and care plan goals/interventions. QAPI Ongoing results will be submitted to QA for further evaluation. Verification of the facility's Corrective Action Plan revealed all elements of plan were met on 2/11/26, as follows: Care plans were updated for triggers for exit seeking behaviors. 17/17 care plans updated to include triggers. All residents with updated elopement risk completed. Orders reviewed, new elopement risk, care plans were updated to include triggers for elopement. All residents identified have orders in place. Elopement binders on units and at front desk with 17 residents at risk for elopement all with identifies/descriptions. 98/108 in-house staff were educated on recognition of exit seeking behaviors, door and wander guard response, supervision of elopement risk residents, care plans and elopement binders, reporting requirements and is ongoing. 23 employee interviews confirmed the education. Review of audits completed on 2/10/26, at 4:00 p.m. fourth floor visitor elevator, service elevator, door one by activities, door two by room [ROOM NUMBER], door three by room [ROOM NUMBER]. No corrective action needed all functioning appropriately. Review of audits completed on 2/10/26, at 4:00 p.m. third floor visitor elevator, service elevator, door one by therapy, door two by room [ROOM NUMBER], door three by room [ROOM NUMBER]. No corrective action needed all functioning appropriately. Facility tour completed on 2/11/26, all doors are functioning appropriately. Audits of assignments sheets (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicate 1:1 scheduled. Audits created for the elopement binders and completed on 2/10/26. The policies around elopement risk and wander guard use have been reviewed by Nursing Home Administrator and [NAME] President of Clinical Operations Employee E7 and Director of Nursing on 2/10/26. QAPI Ongoing results will be submitted to QA for further evaluation. During an interview completed on 2/11/26, at 1:00 p.m. Upon asking Nurse Aid (NA) Employee E38 concerning any education recently received replied yesterday they told us about elopements, a care plan and a binder at the desk, I was not aware of the binder at the desk. During an interview completed on 2/11/26, at 1:04 p.m. Upon asking NA Employee E39 concerning any education recently received replied I had some this morning about elopements, I was not aware of the elopement binders. During an observation and additional interview on 2/11/26, at 3:50 p.m. NA Employee E38 was in Resident R77's room as she had been assigned to provide one on one observation of Resident R77 beginning at 3:00 p.m. Resident was seen walking around his room with his wheeled walker. NA Employee E38 stated that resident likes to walk around a lot and that she was going to take him for a walk on the nursing unit to wear him out. I'm supposed to keep him busy, so he doesn't elope again. I'm going to try to play cards with him later. When SA asked if she had ever conducted these activities with Resident R77 before, she stated No. The Nursing Home Administrator and [NAME] President of Operations Employee E7 were made aware the Immediate Jeopardy was lifted on 2/11/26, at 5:30 p.m. 28 Pa. Code 201.14 (a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of three floors (Third and Fourth Floor). Findings include: Review of the facility policy Safe and Homelike Environment dated 12/11/25, indicated in accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment. Environment refers to any environment in the facility that is frequented by residents including the resident rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas. During an observation on 2/9/26, at 9:32 a.m. the sink in the bathroom of resident room [ROOM NUMBER] was full of water and did not appear to be draining and the faucet was dripping. During an interview on 2/9/26, at 10:12 a.m. Nurse Aide Employee E3 confirmed the sink the bathroom of resident room [ROOM NUMBER] was not draining and stated, They [maintenance] never want to fix the problem. We put in work orders, they'll snake the drain and it'll be ok for a few days, and then it's back to not draining. It happens in a lot of the resident rooms. It's very difficult to get hot water for baths because by the time you turn the water on and it gets warm enough, the sink is about to overflow because it doesn't drain. During an observation on 2/11/26, at 10:13 a.m. the sink in the bathroom of resident room [ROOM NUMBER] was full of water and did not appear to be draining. During an observation on 2/11/26, at 10:27 a.m. the sink in the bathroom of resident room [ROOM NUMBER] was full of water and did not appear to be draining. On 2/12/26, at 10:35 a.m. observation of the Third floor included: room [ROOM NUMBER] had two missing ceiling tiles above the television area, one ceiling tile with brown spots above the television area, and one ceiling tile with dark spots above the resident's bed. Shower Room Stall One- broken plaster on ceiling, and unpainted plaster around the lights. Shower Room Stall Two &ndash; brown spotted area on the ceiling with peeling paint. Brown spotted area on the ceiling with peeling paint above the sink in the shower room. During an interview on 2/12/26, at 10:45 a.m. Maintenance Employee E15 confirmed the above findings on the Third Floor. On 2/12/26, at 10:53 a.m. observation of the Fourth Floor included: room [ROOM NUMBER] Bathroom had plaster peeling and chipping below the sink and around the wall by the floor. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER] Bathroom had plaster peeling and chipping below the sink and around the wall by the floor. The wall by the elevator doors had paint missing in areas. Shower Room Stall One – dark brown areas all around the edges of the shower floor Shower Room Stall Two – dark brown areas all around the edges of the shower floor, and chipped paint throughout the stall. During an interview on 2/12/26, at 11:10 a.m. Maintenance Employee E15 confirmed the above findings on the Fourth Floor. During an interview on 2/12/26, at 2:30 p.m. [NAME] President of Operations Employee E7 confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of three floors (Third and Fourth Floor). 28 Pa. Code 201.18(b)(3)(e)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy, observations and staff interview, it was determined that the facility failed to properly maintain sanitary conditions in the Main Kitchen, by failing to properly label and date food products, and failing to properly store serving scoops, and also failed to maintain sanitary conditions on the third-floor kitchenette which created the potential for cross contamination in one of two kitchenettes (Third floor). Findings include: Review of facility policy Food Storage, dated 12/11/25, indicated that all stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. Scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not to be stored in the food containers but kept covered in a protected area near the containers. During an observation on 2/9/26, at 9:45 a.m. in the Dry Storage area, a bag of croutons, a bag of muffing mix, and a bag of gingerbread mix were found with no label of a receive date, and a bag of cream soup base mix was opened with no date labeled on when it was opened. During an observation on 2/9/26, at 10:00 a.m. a large bin of flour was located in the cook's area with the scoop inside of the bin. During an interview on 2/9/26, at 10:01 a.m. [NAME] Employee E27 confirmed that the facility failed to properly label and date food products, and properly store a serving scoop in the Main Kitchen. During an observation 2/9/26 at 10:00 a.m. of the third-floor kitchenette the following was observed: -Ice machine with covered with a sheet, no lid -January, February 2026 temperature log sheets incomplete. January 13 out of 31 days, February 5 out of 9 days. -Refrigerator: Blue Cheese Dressing, not labelled or dated - (4) reduced fat milk: (1) expired 1/19/26, (3) expired 1/26/26, (2) whole 1/31/26, 2/3/26 - (1) Saralee Bread: no label or date - (1) Bagel: no label or date - (3) Bowls of fruit loops: no label or date During an interview on 2/9/26 at 11:30 a.m., Registered Nurse Employee E5 confirmed that the facility failed to maintain sanitary conditions which created the potential for cross contamination in one of one unit kitchenette. Pa Code 201.14(a) Responsibility of licensee.Pa Code 201.18(b)(3) Management.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of facility documentation, results of previous survey, and results of the current survey, it was determined that the facility Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed deficiencies. Findings include: The facility deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending September 19, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. Findings of the current survey ending February 13, 2026, included deficiencies that were repeated from the previous survey of September 19, 2025, which are as follows: F558, F605, F628, F689, F695, F761, F880, F941, F942, F943, F944, F945, F946, F949, PA1470, PA1550, PA1560, PA1570, and PA1580. During an interview on 2/13/26, at 12:27 p.m., with [NAME] President of Operations Employee E 7 confirmed that the facility had multiple repeat deficiencies from the previous survey, and that the facility failed to correct quality deficiencies and ensure that plans to improve the delivery of care services effectively addressed those deficiencies. 28 Pa. Code 201.18(e)(1) Management28 Pa. Code211.12(c)(d)(3) Nursing services		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 174 Virginia Avenue Rochester, PA 15074	
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for two of two crash carts (Third and Fourth Floor Crash Carts). Findings include: Review of facility policy Emergency Crash Cart dated [DATE], indicated the emergency crash cart is checked every 24 hours and after every use. Missing or expired items are replaced, when applicable. During an observation on [DATE], at 2:04 p.m. of the Fourth Floor Crash Cart revealed a facility document labeled, Crash cart checklist and signature log and failed to have signatures for the following dates: [DATE], was missing signatures from [DATE], [DATE], and [DATE]. [DATE], signature page for the month was missing. During an interview on [DATE], at 9:49 a.m. Registered Nurse Employee E6 stated, The crash cart should be checked every night and signed for and confirmed that the facility failed to make certain equipment was in safe operation condition for the Fourth Floor Crash Cart. During an observation on [DATE], at 9:49 a.m. of the Third Floor Crash Cart revealed the following: One (1) nonconductive suction tubing set (tubing connected to a suction device), expired [DATE] One (1) Yankauer (a type of suction tool, used for clearing secretions such as saliva, mucous, or blood from a patient's mouth and throat), expired [DATE] One (1) 100 milliliter bottle of sterile water, open, with half of contents missing and a large brown circular substance floating in the water During this observation, the State Agency was unable to locate documentation that the Third Floor Crash Cart is checked every 24 hours. During an interview on [DATE], at 9:49 a.m. Licensed Practical Nurse (LPN) Employee E2 stated, I've never seen a check log for this crash cart before. During an interview on [DATE], at 9:49 a.m. LPN Employee E2 confirmed that the facility failed to make certain equipment was in safe operation condition for the Third Floor Crash Cart. 28 Pa. Code: 201.14(a) Responsibility of licensee.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and staff interview, it was determined the facility failed to maintain a fully functioning resident call bell system that allows residents to call for staff assistance through a communication system on two of two nursing units (Third and Fourth Floors). Findings include: Review of the facility policy Call Bells: Accessibility and Timely Response dated 12/11/25, indicated that call bells will directly relay to a staff member or centralized location to ensure appropriate response. Staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call bells. Ensure the call system alerts staff members directly or goes to a centralized staff work area. During an observation on 2/9/26, at 10:18 a.m. the call bell monitoring system at the Fourth Floor nurses station indicated that the call bell for room [ROOM NUMBER], on the Hilltop nursing unit, was activated. The kiosk at the desk visually displayed the room number, but did no sound was heard indicating that a call bell was activated. During an interview on 2/9/26, at 10:24 a.m. Nurse Aide (NA) Employee E3 confirmed that the kiosks located at the nurses stations and in the nursing unit hallways are supposed to visually display which call is activated and make a chime noise. NA Employee E3 stated, Someone must have turned the volume down, I don't know how to turn it back up. I have to make a conscious effort to check the kiosk screens in the hallways and at the desks to see if someone has their call bell on. During an observation on 2/9/26, at 12:39 p.m. several hand bells were observed at the Fourth Floor Nurses Station Registered Nurse (RN) Employee E1 stated, We were told to make sure all of the residents have these hand held bells, I think the call bells might not be working. During an interview on 2/9/26, at 12:40 p.m. NA Employee E3 confirmed that the resident call bells do not illuminate in the hallway outside of the resident rooms and stated, I haven't seen those pagers in over a year. During an observation on 2/9/26, at 1:23 p.m. the kiosk in the Hilltop hallway was noted to be displaying an activated call bell and making a chiming noise to indicate that a call bell was activated. During an observation on 2/9/26, at 1:26 p.m. the kiosk in the Riverview hallway displayed an error message stating, Automatic repair - your PC did not start correctly. The kiosk was not functioning properly during this observation. During an interview on 2/9/26, at 1:27 p.m. NA Employee E4 stated, We used to have pagers, but not recently. We have the kiosks in the hallway that display which call bell is activated. I wish they lit up outside of the rooms, it would be so much easier than carrying a pager. During an observation on 2/9/26, at 1:32 p.m. the kiosk in the Lilac Lane hallway displayed three call bells were activate for rooms [ROOM NUMBER]. The kiosk was not making a chiming sound to indicate that call bells were activated. During an observation on 2/9/26, at 1:34 p.m. the kiosk in the documentation room located in the Rosewood hallway was displaying resident call bells activated, however the volume level was noted to be set to 10 and completely inaudible outside of the documentation room. During an observation on 2/9/26, at 1:37 p.m. the kiosk in the Rosewood hallway displayed call bells were activated, however was not making a chiming sound to indicate that call bells were activated. During an observation on 2/9/26, at 1:38 p.m. the kiosk in the Vineyard hallway was displayed activated call bells and making a chiming noise to indicate that call bells were activated. During an observation on 2/9/26, at 1:41 p.m. the kiosk at the Third Floor Nurses Station was black and did not appear to be turned on. Registered Nurse (RN) Employee E5 stated, It may have gotten bumped and unplugged under the desk. During an interview on 2/9/26, at 1:46 p.m. RN Employee E5 stated, I've worked here for almost a year and we've never used a pager, I didn't know anything about it until I was told today. During an interview on 2/9/26, [NAME] President of Operations (VPO) Employee E7 stated, Sometimes the call system needs to be reset, I'm sure that's what it was. During an observation on 2/12/26, at 2:05 p.m. the kiosk in the Hilltop hallway indicated a call bell was activated, however the kiosk failed to make a chiming sound to indicate that a call bell was activated. During an interview on 2/12/26, at 2:07 p.m. NA Employee E37 stated, Maintenance (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reset the call bell system earlier today, it wasn't working a little before lunch. It wasn't working down the Hilltop hallway. During an observation on 2/12/26, at 2:07 p.m. the Fourth Floor Nurses Station kiosk was displaying that a call bell was activated, however was not making a chiming noise to indicate that a call bell was activated. During an interview on 2/12/26, at 2:08 p.m. Licensed Practical Nurse Employee E12 stated, I definitely heard the call bells chiming yesterday, I can't recall if I've heard them today. During an observation on 2/12/26, at 2:09 p.m. the kiosk in the Grandview hallway was displaying that a call bell was activated, however was not making a chiming noise to indicate that a call bell was activated. During an observation on 2/12/26, at 2:10 p.m. the kiosk in the Riverview hallway was displaying that a call bell was activated, however was not making a chiming noise to indicate that a call bell was activated. During this observation, NA Employee E37 refreshed the kiosk screen and a chiming sound was heard. NA Employee E37 stated, I think the Wi-Fi goes in and out and that's what causes the call bell system to need to be refreshed. During an observation on 2/12/26, at 2:19 p.m. the kiosk in the Rosewood hallway was displaying that a call bell was activated, however was not making a chiming noise to indicate that a call bell was activated. During an observation on 2/12/26, at 2:20 p.m. the kiosk in the documentation room located in the Rosewood hallway had a black screen and did not appear to be turned on. During an interview on 2/12/26, at 2:24 p.m. VPO Employee E7 stated that the facility will immediately implement a monitoring system to ensure that the call bell system is functioning appropriately on the Third and Fourth Floor Nursing Units and ensure that all residents have access to the hand held bells. VPO Employee E7 stated that maintenance was made aware of the call system concerns and education is being provided to all nursing staff regarding ensuring that the call bell system is functioning appropriately and what to do in the event that the system is identified as not functioning appropriately. During an observation on 2/13/26, at 9:02 a.m. the kiosk in the Riverview hallway was observed to be functioning appropriately. During an observation on 2/13/26, at 9:05 a.m. the kiosks in the Hilltop and Grandview hallways and the kiosk at the Fourth Floor Nurses Station were displaying that a call bell was activated, however none of the kiosks were making a chiming noise to indicate that a call bell was activated. During an observation on 2/13/26, at 9:10 a.m. the Third Floor Nurses Station kiosk and the kiosks in the Rosewood, Lilac Lane, and Vineyard hallways were observed to be functioning appropriately. During an interview on 2/13/26, at 10:07 a.m. VPO Employee E7 stated, We [administration] were made aware of the call bell system not functioning about 20 minutes ago. The administrative team immediately went and rounded on both nursing units and turned up the volume on all of the kiosks. We believe that staff are turning the volume down at night for the comfort of the residents as the chiming sound is loud. We have disabled the volume function on all the kiosks, staff will no longer be able to adjust the volume of the call bells on the kiosks. We have the pagers here in the office but we need to get a few more so all nursing staff can be provided with one during their shift. We will provide an in-service on how to use the pagers once they have all been obtained. The goal is for the nurses to receive all of the call notifications and the nurse aides will receive call bell notifications for their specific assignments. During an interview on 2/13/26, at 10:07 a.m. VPO Employee E7 confirmed that the facility failed to maintain a fully functioning resident call bell system that allows residents to call for staff assistance through a communication system on two of two nursing units (Third and Fourth Floors). 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 205.28(c)(1) Nurses station.28 Pa. Code: 205.67(k) Electric requirements for existing construction.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of five residents sampled with facility-initiated transfers (Resident R2, R6, R52, R84, and R89), and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for five of five resident hospital transfers (Resident R2, R6, R52, R84, and R89). Findings include: Review of facility policy Transfer and Discharge (including AMA) dated 12/11/25, indicated for a transfer to another provider, for any reason, the following information must be provided to the receiving provider: Contact information of the practitioner who was responsible for care of the resident; Resident representative information, including contact information; Advance directive information; All other information necessary to meet the resident's needs, which includes, but may not be limited to: resident status, diagnoses and allergies, medications (including when last received), and most recent relevant labs, other diagnostic test, and recent immunizations All special instructions and/or precautions for ongoing care, as appropriate; The resident's comprehensive care plan goals Document assessment findings and other relevant information regarding the transfer in the medical record. Review of facility policy Bed Hold Notice dated 12/11/25, indicated in the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/9/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of the clinical record indicated Resident R2 was transferred to the hospital on 1/7/26, and returned to the facility on 1/8/26. Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R2's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/7/26. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, malnutrition (lack of nutrients in the body), and hypokalemia (low levels of potassium in the blood). Review of the clinical record indicated Resident R6 was transferred to the hospital on [DATE] and returned to the facility on 1/27/26. Review of Resident R6's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R6's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on [DATE]. Review of the clinical record revealed Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's MDS dated [DATE], indicated diagnoses of abnormal weight loss, Down Syndrome (a genetic condition that affects how a person's body and brain develop, leading to physical and developmental challenges), and need for assistance with personal care. Review of the clinical record indicated Resident R52 was transferred to the hospital on [DATE], and returned to the facility on 1/14/26. Review of Resident R52's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R52's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on [DATE]. Review of the clinical record indicated Resident R52 was transferred to the hospital on 1/11/26, and returned to the facility on 1/14/26. Review of Resident R52's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R52's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/11/26. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE]. Review of Resident R84's MDS dated [DATE], indicated diagnoses of heart failure, diabetes, and high blood pressure. Review of the clinical record indicated Resident R84 was transferred to the hospital on 1/29/26, and did not return back to the facility at this time. Review of Resident R84's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R84's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/29/26. Review of the admission record indicated Resident R89 was admitted to the facility on [DATE]. Review of Resident R89's MDS dated [DATE], indicated the diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and hemiplegia (paralysis of half of the body) of the right side. Review of the clinical record indicated Resident R89 was transferred to the hospital on [DATE], and did not return back to the facility at this time. Review of Resident R89's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R89's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on [DATE]. During an interview on 2/12/26, at 2:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of five residents sampled with facility-initiated transfers (Resident R2, R6, R52, R84, and R89), and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for five of five resident hospital transfers (Resident R2, R6, R52, R84, and R89). 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for three of five residents (Resident R2, R4, and R60) and failed to follow physician orders for weights for one of two residents (Resident R16). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus (DM) is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 mg/dL (milligrams per deciliter). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the clinical record revealed Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/9/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of a physician order dated 7/8/25, indicated accucheck (capillary blood glucose check) without coverage two times a day. The physician order failed to contain parameters for when to contact the physician regarding low or high capillary blood glucose checks. Review of Resident R2's vitals record indicated the following capillary blood glucose measurements: 1/11/26 at 7:45 a.m. = 374 mg/dL 1/12/26 at 7:53 p.m. = 392 mg/dL 1/16/26 at 6:21 p.m. = 447 mg/dL 1/21/26 at 7:22 p.m. = 372 mg/dL (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/22/26 at 6:55 p.m. = 352 mg/dL 1/26/26 at 7:53 p.m. = 448 mg/dL 1/27/26 at 6:38 p.m. = 487 mg/dL 1/29/26 at 10:22 p.m. = 395 mg/dL 1/30/26 at 10:19 p.m. = 395 mg/dL 2/17/26 at 7:13 a.m. = 421 mg/dL Review of Resident R2's progress notes from 1/11/26, through 2/17/26, failed to include documentation that the physician was notified of the resident's increased blood glucose levels on the dates listed above. During an interview on 2/10/26, at 12:40 p.m. Registered Nurse (RN) Employee E6 stated, I would notify the physician of those blood sugar readings. During this interview, RN Employee E6 confirmed the physician order failed to include parameters for when to contact the physician regarding low or high capillary blood glucose checks and that Resident R2's clinical record failed to include documentation that the physician was notified of the resident's increased blood glucose levels. Review of the clinical record revealed Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and hemiplegia (paralysis on one side of the body). Review of a physician order dated 9/15/25, indicated accucheck without coverage two times a day. The physician order failed to contain parameters for when to contact the physician regarding low or high capillary blood glucose checks. Review of Resident R4's vitals record indicated the following capillary blood glucose measurements: 1/21/26 at 5:12 a.m. = 381 mg/dL 1/29/26 at 8:36 p.m. = 423 mg/dL 2/3/26 at 8:21 p.m. = 376 mg/dL Review of Resident R4's progress notes from 1/1/26, through 2/10/26, failed to include documentation that the physician was notified of the resident's increased blood glucose levels on the dates listed above. During an interview on 2/10/26, at 12:49 p.m. RN Employee E6 stated, I would notify the physician of those blood sugar readings. During this interview, RN Employee E6 confirmed the physician order failed to include parameters for when to contact the physician regarding low or high capillary blood glucose checks and that Resident R4's clinical record failed to include documentation that the physician was notified of the resident's increased blood glucose levels. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R60 was admitted to the facility on [DATE]. Review of Resident R60's MDS dated [DATE], indicated diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and chronic obstructive pulmonary disease. (COPD- makes breathing difficult) Review of Resident R60's physician orders dated 2/5/26, indicated glucometer checks with Humalog administration with meals. The physician order failed to contain parameters for when to contact the physician regarding low or high capillary blood glucose checks. Review of Resident R60s vitals record indicated the following capillary blood glucose measurements: 2/7/26 at 9:56 a.m. = 469 mg/dL 2/9/26 at 11:12 a.m. = 427 mg/dL 2/9/26 at 3:01 p.m. = 437 mg/dL 2/10/26 at 7:29 a.m. = 460 mg/dl Review of Resident R60's progress notes from 2/7/26, through 2/10/26, failed to include documentation that the physician was notified of the resident's increased blood glucose levels on the dates listed above. During an interview completed on 2/12/26, at 10:03 a.m. RN Employee E13 confirmed that the physician orders failed to include parameters for when to contact the physician and that Resident R60's clinical record failed to include documentation that the physician was notified of the resident's increased blood glucose levels. RN Employee E13 stated the physician should be notified on any reading over 400 and confirmed the facility failed to make certain that residents were provided appropriate treatment and care for three of five residents (Resident R2, R4, and R60). Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's MDS dated [DATE], indicated diagnoses of anemia (low iron in the blood) and hypertension (high blood pressure) and lymphedema (fluid builds up in tissue causing swelling). Review of Resident R16's physician orders dated 11/18/25, indicated weigh two times a week every Tuesday and Friday for lymphedema. Review of Resident R16's weights summary report indicated that the weights were only obtained on the following days: 12/2/25, 12/9/25, 12/19/25, 12/23/25, 12/26/25, 1/20/26, 1/30/26 and 2/7/26. During an interview completed on 2/13/26, at 11:27 a.m. upon asking Registered Nurse (RN) Employee E5 concerning Resident R16's weights replied The last time Resident R16 was weighed was on 2/7/26, the weights are supposed to be completed two times a week. They are not being done consistently. I put a list out every morning, I can only tell them (other licensed staff) so many times. There are gaps in the weight records. The documentation has also been an issue with some of the staff and confirmed that the facility failed to follow physician orders for weights for one of two residents (Resident R16). (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents and staff interviews, it was determined that the facility failed to ensure residents were assessed, and provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for three of four residents (Resident R3, R9, and R55).Findings include: Review of facility policy Pressure Injury Prevention Guidelines dated 12/11/25, indicated to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of the facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/8/26, indicated diagnoses diabetes mellitus, unspecified dementia (group of symptoms that cause a loss of cognitive functioning), and autistic disorder (neurological and developmental disorder). Review of Resident R3's clinical wound progress note dated 1/3/26, revealed that coccyx is a Stage 2 Pressure ulcer, no measurements at admission. Review of Resident R3's indicated a measurement on 1/8/26. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses diabetes mellitus, hypertension and anxiety disorder. Review of Resident R9's clinical wound progress note dated 1/12/26, revealed that sacrum is a Stage 3 Pressure ulcer, no measurements at admission. Review of Resident R9's indicated a measurement on 1/15/26. During an interview on 2/12/26, at 2:00 p.m., Registered Nurse Clinical Consultant Employee E14 confirmed that the facility failed to ensure residents were assessed, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of two residents (Resident R3, R9). Review of the clinical record revealed Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question M0300C indicated the resident had one stage 3 pressure ulcer (full thickness tissue loss). Review of a physician order dated 12/29/25, indicated right buttock - cleanse buttock with soap and water, pat dry, apply a thick layer of Calmoseptine (Menthol-Zinc Oxide, a topical ointment used to (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protect and heal skin irritations caused by moisture) every shift and as needed when soiled for S3PI (Stage 3 Pressure Injury). Review a skin and wound progress note dated 1/15/26, partial thickness coccyx wound extending to bilateral buttock resolved at this time. Recommend continuing zinc paste for protection and prevention of future IAD (Incontinence Associated Dermatitis) as per the facility protocol. Review of Resident R55's January 2026 Treatment Administration Record (TAR) revealed the treatment was not signed off as completed or refused on the following shifts: 1/12/26, 7 a.m. - 3 p.m. shift 1/14/26, 7 a.m. - 3 p.m. shift 1/23/26, 7 a.m. - 3 p.m. shift 1/25/26, 3 p.m. - 11 p.m. shift 1/30/26, 7 a.m. - 3 p.m. shift 1/31/26, 7 a.m. - 3 p.m. shift Review of Resident R55's February 2026 TAR revealed the treatment was not signed off as completed or refused on the following shifts: 2/1/26, 7 a.m. - 3 p.m. shift 2/5/26, 7 a.m. - 3 p.m. shift 2/6/26, 7 a.m. - 3 p.m. shift Review of a physician order dated 10/26/23, indicated weekly skin assessment: document in medical record under assessment tab, skin alteration assessment every evening shift every Friday. Review of Resident R55's clinical record failed to contain documentation that a skin assessment had been performed as ordered for the following weeks: 1/18/26 - 1/24/26 1/25/26 - 1/31/26 2/1/26 - 2/7/26 During an interview on 2/13/26, at 11:38 a.m. [NAME] President of Operations Employee E7 confirmed that the facility failed to ensure Resident R55 received monitoring and provided necessary treatment and services consistent with professional standards of practice for pressure ulcers. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10 (c)(d) Resident care policies. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for five of six residents (Resident R2, R29, R34, R60 and R65). Findings include: Review of facility policy Oxygen Concentrator dated 12/11/25, indicated this policy is to establish responsibilities for the care and use of oxygen concentrators. Oxygen is administered under orders of the attending physician. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Review of the facility policy Oxygen Administration dated 12/11/25, indicated oxygen is administered to residents who need it, consistent with professional standards of practice. Infection control measures include but not inclusive to change the oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. If applicable, change the nebulizer tubing and delivery device every 72 hours or per facility policy and as needed if they become soiled or contaminated. Keep delivery devices covered in a plastic bag when not in use. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/9/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. Review of Resident R2's physician orders dated 9/17/23, indicated to administer oxygen via nasal cannula (a thin tubing that delivers oxygen from the oxygen concentrator to the nose) three to four liters per minute every shift for chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R2's physician orders dated 8/30/24, indicated to change oxygen tubing and filter weekly, every night shift on Tuesdays. Review of Resident R2's physician orders dated 1/13/26, indicated Ipratropium-Albuterol Solution (a medication used to treat lung diseases) inhale orally every six hours as needed via nebulizer (a machine used to deliver medication). During an observation on 2/9/26, at 10:45 a.m. Resident R2 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. Oxygen tubing was dated 1/28/26, and the nebulizer tubing was dated 1/1/26, and was not stored in a bag when not in use. Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE]. Review of Resident R29's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and respiratory failure (a condition where the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide from it). Review of Resident R29's physician orders dated 11/7/25, indicated to administer oxygen via nasal cannula as needed to keep oxygen saturations greater than 90 percent, for hypoxia (low oxygen in blood). Review of Resident R29's physician orders dated 10/16/25, indicated to change oxygen tubing and filters weekly every night shift on Tuesdays. During an observation on 2/9/26, at 10:55 a.m. Resident R29 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. Oxygen tubing was dated 1/28/26. Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE]. Review of Resident R34's MDS dated [DATE], indicated diagnoses of hyperlipidemia (high fat in the blood), anxiety and chronic obstructive pulmonary disease (COPD- causes restricted airflow and breathing problems). Review of Resident R34's physician orders dated 1/25/25, indicated Ipratropium-albuterol solution 0.5-2.5milligrams (mg) 3milliliter (ml) (medication that relaxes the airway muscles to increase airflow to the lungs) inhale orally via nebulizer every 6 hours for wheezing. During an observation completed on 2/9/26, at 11:12 a.m. Resident R34's nebulizer was sitting on top of his bedside table not stored in a bag as required. During an interview completed on 2/9/26 at 11:21 a.m. Registered Nurse (RN) Employee E5 confirmed Resident R34's nebulizer was sitting on the bedside table not stored in a bag as required. Review of the clinical record indicated Resident R60 was admitted to the facility on [DATE]. Review of Resident R60's MDS dated [DATE], indicated diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and COPD. Review of Resident R60's physician orders dated 1/29/26, indicated oxygen at 2 liters per minute (lpm) via nasal canula as needed. During an observation completed on 2/9/26, at 11:23 a.m. Resident R60 was in bed her oxygen was on via nasal canula, the tubing failed to be labeled with a date as required. During an interview completed on 2/9/26 at 11:26 a.m. Registered Nurse (RN) Employee E5 confirmed Resident R60's oxygen tubing failed to be labeled with a date as required. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated diagnoses of diabetes, dementia, and respiratory failure. Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R65's physician orders dated 2/4/24, indicated to administer oxygen via nasal cannula two liters per minute every shift for COPD. Review of Resident R65's physician orders dated 8/30/24, indicated to change oxygen tubing and filter weekly, every night shift on Tuesdays. Review of Resident R65's physician orders dated 1/21/26, indicated Albuterol Sulfate Inhalation Nebulization Solution (a medication used to treat lung diseases) inhale orally every six hours as needed for shortness of breath. Review of Resident R65's physician orders dated 1/2/26, indicated to change nebulizer tubing and filter weekly every night shift on Tuesdays. During an observation on 2/9/26, at 11:10 a.m. Resident R65 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. Oxygen tubing was dated 1/28/26, and the nebulizer tubing was dated 1/28/26, and was not stored in a bag when not in use. During an interview on 2/9/26, at 12:20 p.m. Registered Nurse Employee E1 confirmed that the facility failed to provide appropriate respiratory care for Residents R2, R29, and R65. During an interview completed on 2/9/26, at 3:28 p.m. the [NAME] President of Operations Employee E7 confirmed that the facility failed to provide appropriate respiratory care for five of six residents (Resident R2, R29, R34, R60 and R65). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly secure a treatment cart while not in use for one of two treatment carts (4th Floor Treatment Cart), failed to properly secure lab work supplies while not in use for one of two nursing units (4th Floor), and failed to properly store medication in two of three medication carts (Grandview Medication Cart and Riverview Medication Cart). Findings include: Review of facility policy Medication Storage dated 12/11/25, indicated all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During an observation on 2/9/26, at 12:15 p.m. the 4th Floor Treatment Cart was observed at the nurses station unlocked and unattended. During an observation on 2/9/26, at 12:19 p.m. a plastic portable caddy was observed at the 4th Floor nurses station unsecured and unattended. The caddy contained the following lab work supplies: Twelve (12) 25 gauge blood collection needle and tubing sets Seven (7) 22 gauge needles Four (4) 21 gauge needles During an interview on 2/9/26, at 12:21 p.m. Registered Nurse (RN) Employee E1 confirmed that the facility failed to properly secure the 4th Floor Treatment Cart while not in use and failed to properly secure lab work supplies while not in use on the 4th Floor. During a medication cart review (Grandview Medication Cart) on 2/10/26, at 9:40 a.m. the following were observed: Two Lantus Insulin Pen (medication used to treat high blood sugar) &ndash; No open or expiration date noted and no residents name on the pens. During an interview on 2/10/26, at 9:54 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed the above findings. During a medication cart review (Riverview Medication Cart) on 2/11/26, at 12:01 p.m. the following were observed: Three medication cups with two light colored pills in each cup sitting in the cart's top drawer. Pills were unmarked, unlabeled, and unsecured. During an interview on 2/11/26, at 12:04 p.m. LPN Employee E11 stated, They are not mine. and (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed the above findings. During an observation on 2/12/26, at 8:50 a.m. the 4th Floor Treatment Cart was observed in the hallway, unlocked and unattended. During an interview on 2/12/26. At 8:53 a.m. LPN Employee E12 confirmed that the 4th Floor Treatment Cart was unlocked and unattended. 28 Pa. Code: 201(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of job descriptions, facility and clinical records, and staff interviews, it was determined that the former Nursing Home Administrator (NHA) Employee E31 and the Director of Nursing (DON) did not effectively manage the facility to make certain that proper supervision was provided for residents at high risk for elopement as required, resulting in a resident elopement creating an immediate jeopardy situation. Findings include: The job description for the Nursing Home Administrator (NHA) dated 2/9/26, indicated the NHA leads, guides, and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards, and established facility policies and procedures to provide appropriate care and services to residents. Ensures delivery of compassionate quality care and services across an interdisciplinary team. Performs rounds to observe residents and ensure overall needs are met. Ensures resident incidents and concerns that rise to a reportable event including but not inclusive to such alleged abuse, neglect, mistreatment, misappropriation are reported to the correct entity within the stated regulatory requirement. The job description for the Director of Nursing (DON) dated 10/16/25, indicated the DON is to plan, organize, develop, and direct the overall operations of the nursing service department. Monitors for allegations of potential abuse, neglect or misappropriation of resident property and participates in the investigation process. Oversees resident incidents and concerns daily to identify any unusual occurrences and reports them promptly to the NHA and or state agency for appropriate action. Establishes a culture of compliance by adhering to all facility policies and procedures. Based on the findings in this report that identified that the facility failed to effectively manage the facility to make certain that proper supervision was provided for residents at high risk for elopement as required, resulting in a resident elopement creating an immediate jeopardy situation. The facility failed to provide fundamental principal that apply to treatment and care provided to facility residents. The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, and facility policies. 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(b)(1)(e)(1) Management.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that hospice documentation was maintained for three of three residents reviewed for hospice services (Resident R9, R23, and R65). Findings include: Review of facility policy Coordination of Hospice Services 12/11/25, indicated 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. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/17/26, indicated diagnoses diabetes mellitus, hypertension and anxiety disorder. Review of Resident R9's physician orders dated 1/13/26 revealed an order for hospice services. Resident R9 clinical record lacked evidence that the hospice agency provided the facility with communication and there was no hospice binder indicating current plan of care or hospice documentation. During an interview on 2/11/26, at 11:00 a.m., [NAME] president of Operations Employee E7 confirmed that Resident R9 clinical record lacked hospice communication and there was no hospice binder as required. Review of the clinical record revealed Resident R23 was admitted to the facility on [DATE]. Review of Resident R23's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and depression. Review of a physician order dated 1/2/26, indicated resident is admitted to hospice services 11/6/23 for diagnosis of end stage cardiac disease. Review of Resident R23's clinical record on 2/10/26, revealed a Hospice Certification and Plan of Care dated 12/30/24 - 2/27/25. Review of the clinical record failed to include a recent hospice plan of care. During an interview on 2/10/26, at 1:38 p.m. Registered Nurse (RN) Employee E6 confirmed that Resident R23's clinical record lacked a current hospice plan of care and that the facility failed to ensure hospice documentation was maintained for Resident R23. Review of the clinical record indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and respiratory failure (a condition where the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide from it). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 174 Virginia Avenue Rochester, PA 15074	
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R65's physician orders dated 6/27/24, revealed an order for hospice services for chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R65's hospice communication binder on 2/10/26, revealed the last plan of care was dated 4/23/25 - 6/21/25, and the last documented visit from hospice was 10/1/25. During an interview on 2/10/26, at 1:37 p.m. Registered Nurse Employee E6 confirmed that Resident R65's clinical record and hospice communication binder failed to have a current plan of care or hospice documentation. 28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 211.12(d)(1)(3) Nursing services		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policies, clinical record review, facility documents, observation, and staff interview, it was determined that the facility failed to ensure proper hand hygiene on six of six nursing units (Lilac Lane, Rosewood, Vineyard, Riverview, Hilltop, and Grandview), failed to prevent cross contamination during a dressing change for one of two residents (Resident R9), failed to properly monitor a resident's refrigerator temperature for one of two residents (Resident R44), and failed to monitor the results of blood cultures (a blood test used to determine if infection is present in blood stream) for one of three residents (Resident R2). Finding include: Review of facility policy Hand Hygiene dated 12/11/25, indicated that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method of cleaning hands in most clinical situations. All staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to putting gloves on, and immediately after removing gloves. Review of the facility policy Clean Dressing Change reviewed 12/11/25, indicated the facility will provide wound care in a manner to decrease potential for infection and cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Review of facility policy Resident refrigerators: dated 12/11/25 indicated that the facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. Maintenance Staff shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator. During an observation on 2/9/26, at 9:50 a.m. three out of three hand sanitizer dispensers located on the Fourth floor were noted to be empty. During an interview on 2/9/26, at 10:11 a.m. Infection Preventionist (IP) Employee E10 confirmed that there has been no hand sanitizer in the wall dispensers since the recall that was initiated by the manufacturer in September of 2025. IP Employee E10 stated, It's been ordered six times, but it keeps going to other facilities. During an interview on 2/11/26, at 9:37 a.m. Registered Nurse (RN) Employee E5 confirmed that the wall dispensers for hand sanitizer, and soap have been empty since the manufacturer recall in September of 2025, but that they have pocket sized hand sanitizer for employees and they have bottles on the medication cart. RN Employee E5 confirmed that the wall dispensers would be more convenient, especially for use of visitors. During observations conducted on 2/11/26, from 9:51 a.m. through 11:30 a.m. State Agency (SA) initiated rounds in all resident restrooms to ensure that residents had access to hand soap. The following rooms did not have any hand soap: Lilac Lane:310314326 Riverview:408412414418420422424426 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hilltop:435437439 Grandview:453462 Review of the above data indicated that no hand soap was present for 17 of 62 resident restrooms. During observations conducted on 2/11/26, from 9:51 a.m. through 11:30 a.m. State Agency (SA) initiated rounds in all Nursing Unit hallways to determine availability of hand sanitizer in the wall dispensers. The results are as follows: Lilac Lane: six of six hand sanitizer dispensers were empty. Rosewood: seven of seven hand sanitizer dispensers were empty. Vineyard: four of four hand sanitizer dispensers were empty. Riverview: four of four hand sanitizer dispensers were empty. Hilltop: seven of seven hand sanitizer dispensers were empty. Grandview: four of four hand sanitizer dispensers were empty. Review of the above data indicated that no hand sanitizer was present in 32 of 32 wall dispensers. During an interview on 2/11/26, at 12:30 p.m. Nurse Aide (NA) Employee E22 confirmed that there is no hand soap in many of her resident rooms. When asked what she does when she needs to wash her hands before or after giving care to a resident that does not have hand soap in their rest room, NA Employee E22 replied I have brought my own soap before. Sometimes you just go to the next room (to wash your hands), and that one can be empty or broken. It should be in there. During an interview on 2/11/26, at 12:39 p.m. NA Employee E23 stated I don't know why they haven't ordered it (hand soap). During an observation on 2/11/26, at 12:46 p.m. in Central Supply, two pump bottles, and five cases of hand sanitizer were present, but no hand soap was detected. During an interview on 2/11/26, at 1:43 p.m. Housekeeping Employee E24 stated that he has large, gallon bottles of hand soap available to refill existing hand soap dispensers/pumps, but that he only has one hand soap dispenser/pump available to distribute. During an interview on 2/11/26, at 2:08 p.m. Central Supply (CS) Employee E25 confirmed that hand soap is not kept in Central Supply, but that it is kept in Housekeeping. CS Employee E25 stated that Housekeeping Director was gone for the day, but that she would have someone open the Housekeeping Supply closet to determine if any hand soap was available. During an observation on 2/11/26, at 2:33 p.m. the [NAME] President of Operations (VPO) Employee E7 arrived with Maintenance to open Housekeeping Supply closet, and zero bottles of hand soap were present in storage, which was confirmed by VPO Employee E7. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/11/26, at 3:08 p.m. CS Employee E25 had displayed bags from the store from which she had been sent to purchase over 40 bottles/dispensers of hand soap to distribute to resident rooms that did not have any soap. CS Employee E25 stated that she had been sent to purchase these by VOP Employee E7 after it was discovered that there were no hand soap dispensers available for use. During an interview on 2/12/26, at 8:49 a.m. Housekeeping Director (HD) Employee E26 stated that he had just started at the facility one week ago but is aware that the facility had a recall on the hand sanitizer and hand soap from the manufacturer. HD Employee E26 stated that there are other manufactures that could be ordered from, and that he will be contacting them immediately. During an interview on 2/12/26, at 10:10 a.m. VPO Employee E7 stated that she was not aware that the facility did not have adequate hand soap and hand sanitizer, and was not informed by the former Nursing Home Administrator that this was an ongoing problem since September 2025. VPO Employee E7 confirmed that it was unacceptable to not have hand soap and hand sanitizer available, and confirmed that the facility failed to ensure proper hand hygiene for six of six nursing units. During an observation on 2/9/26, at 11:33 a.m. Resident R44 had a small personal refrigerator on the bedside nightstand. During an observation on 2/9/26, at 11:35 a.m. the contents inside included three boost, two cartons of milk, apple cider, yogurt, salami, cream cheese, and salsa. During an observation on 2/9/26, at 11:45 a.m. there was no temperature log that included daily monitoring for Resident R44's personal refrigerator and failed to have a thermometer inside the refrigerator. During an interview on 2/9/26, at 12:17 p.m. Registered Nurse Employee E1 confirmed that the facility failed to properly monitor a resident's refrigerator temperature for one of two residents (Resident R44). Review of the clinical record revealed Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/17/26, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and repeated falls. Review of a physician order dated 1/15/26, indicated sacrum (bottom of spine) - cleanse with soap and water, pat dry. Apply medical grade honey (a wound gel used to support healing and infection control) and cover with bordered gauze (an absorbent adhesive dressing). To be changed daily and PRN (as needed) for soilage/dislodgement. During a dressing change observation on 2/11/26, from 11:05 a.m. to 11:19 a.m. RN Employee E6 failed to perform hand hygiene prior to donning a clean pair of gloves prior to cleansing the wound, after cleansing the wound, and prior to placing the new dressing on the wound. During an interview on 2/11/26, at 11:20 a.m. RN Employee E6 confirmed the above observations and that the facility failed to prevent cross contamination during a dressing change for Resident R9. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R2's clinical record revealed that resident was sent to the hospital on 1/7/26, and returned to facility on 1/8/26. While in the hospital, Resident R2 completed a set of blood cultures. During a review of hospital documents on 2/12/26, at 11:05 a.m. revealed pending studies at the time of discharge listed Blood cultures completed on 1/7/26. During a review of Resident R2's clinical record on 2/12/26, at 11:15 a.m. failed to include final results of blood cultures that were pending during hospital visit. During an interview on 2/12/26, at 12:25 p.m. Registered Nurse Infection Preventionist Employee E10 stated, I usually look up the results after they get back from the hospital. I must have missed that one. I will call the hospital to get the results and then add them to Resident R2's medical record. During an interview on 2/12/26, at 12:31 p.m. Registered Nurse Infection Preventionist Employee E10 confirmed that the facility failed to monitor the results of blood cultures for one of three residents (Resident R2). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to timely offer and provide the COVID-19 vaccination for three of five residents (Residents R16, R71, and R72). Findings include: Review of facility policy COVID-19 - Vaccination Policy dated 12/11/25, indicated all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. Prior to receiving vaccination, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. Provision of such education shall be documented in the resident's medical record. If vaccines are refused, the refusal shall be documented in the resident's medical record. Review of the clinical record revealed Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/27/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and muscle weakness. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R16's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since admission on [DATE]. Review of the clinical record revealed Resident R71 was admitted to the facility on [DATE]. Review of Resident R71's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and hemiplegia (paralysis on one side of the body). Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of a progress note dated 11/24/25, stated, Spoke with resident on vaccinations. He is up to date with his Flu (influenza) vaccine. He is interested in the pneumococcal, COVID, and RSV vaccines but not all at the same time. Prevnar 20 (pneumococcal) ordered for tomorrow morning and will give VIS (Vaccine Information Statements) sheet in near future. Review of Resident R71's clinical record failed to include documentation that the COVID-19 vaccination was administered as requested since admission on [DATE]. Review of the clinical record revealed Resident R72 was admitted to the facility on [DATE]. Review of Resident R72's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and muscle weakness. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of a progress note dated 11/24/25, stated, Spoke with and educated brother and nephew regarding vaccinations. Nephew requests vaccinations but not at the same time. Administered Fluad Influenza vaccine in left deltoid (upper arm). Resident tolerated well. Temperature 97.4 degrees Fahrenheit. Unit nurse made aware. VIS left for nephew, as discussed on the phone. Review of Resident R72's clinical record failed to include documentation that the COVID-19 vaccination was administered as required since admission on [DATE]. During an interview on 2/11/26, at 11:33 a.m. Infection Preventionist Employee E10 stated, COVID vaccines were offered, we switched pharmacies, I was going to do a big COVID vaccine administration in February. They [residents] probably want it, I haven't been able to get a huge batch yet. During an interview on 2/11/26, at 11:33 a.m. Infection Preventionist Employee E10 confirmed that the facility failed to timely offer and provide the COVID-19 vaccination for three of five residents (Residents R16, R71, and R72). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.5(f) Medical records.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for two of five residents (Residents R23 and R55). Findings include: Review of facility policy Call Lights: Accessibility and Timely Response dated 12/11/25, indicated staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. Review of the clinical record revealed Resident R23 was admitted to the facility on [DATE]. Review of Resident R23's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/8/26, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and depression. During an observation on 2/9/26, at 9:28 a.m. Resident R23 was observed lying in their bed. Resident R23's call bell was wrapped around the headboard, out of the resident's reach. Review of the clinical record revealed Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 2/9/26, at 9:39 a.m. Resident R55 was observed lying in their bed. Resident R55's call bell was wrapped around the headboard, out of the resident's reach. During an interview on 2/9/26, at 10:12 a.m. Nurse Aide Employee E3 confirmed Resident R23 and Resident R55's call bells were not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident 23 and Resident R55's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that each resident's drug regimen was free from unnecessary psychotropic drugs used without adequate indications for use for one of three residents (Resident R77). Findings include: Review of the admission record indicated Resident R77 was admitted to the facility on [DATE] Review of Resident R77's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/5/25, indicated the diagnoses of hypertension (high blood pressure), depression, and hyperlipidemia. Review of Section N: Medications revealed Resident R77 received antipsychotic medications in the seven days prior to the assessment and that an indication is noted Review of Resident R77's physician order dated 8/5/25, indicated risperidone 0.5 milligram tablet two times a day for agitation. Review of Resident R77's psychiatric progress note dated 8/21/25, indicated diagnosis dementia with other behavioral disturbance (symptoms that occur alongside cognitive decline that include but not inclusive to agitation, wandering and anxiety) continue with risperidone 0.5 mg two times a day. Review of Resident R77's care plan with revision on 11/24/25, indicated I have potential for adverse reactions from: use of psychotropic med. Major depressive disease (MDD) and Dementia with other behavioral disturbance. Review of Resident R77's psychiatry progress note dated 1/8/26, indicated psychiatric follow up for Dementia with behavioral symptoms and psychotic features. Continue risperidone at current dose. During an interview completed on 2/12/26, at 10:40 a.m. Registered Nurse Employee E13 confirmed that Resident R77 did not have a diagnosis for the use of risperidone and that the facility failed to make certain that each resident's drug regimen was free from unnecessary drugs used without adequate indications for use for one of three residents (Resident R77). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.2(a)(c) Physician services. 28 Pa. Code: 211.9(a)(1)(d)(k) Pharmacy services.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, newly hired personnel records and staff interviews it was determined that the facility failed to properly screen an employment by completing a state certification/license check prior to hire for two out of five personnel records (Nurse Aide (NA) Employee E19 and Licensed Practical Nurse (LPN) Employee E20). Findings include: Review of the facilities Abuse, Neglect and Exploitation policy dated 12/11/25, indicated the facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Screening: potential employees will be screened for a history of abuse, neglect, exploitation, and misappropriation of resident property. Background, reference, and credentials' checks will be conducted on potential employees. Review of the facilities License Verification policy dated 12/11/25, indicated all personnel that requires a license or certification shall be verified through the appropriate issuing agency. Review of NA Employee E19's personnel record indicated she was hired on 1/21/26. Review of NA Employee E19's personnel record did not include a completed certification check prior to the date of hire. Review of LPN Employee E20's personnel record indicated she was hired on 1/21/26. Review of LPN Employee E20's personnel record did not include a completed LPN license check prior to the date of hire. During an interview on 2/10/26, at 3:50 p.m. the Human Resources Employee E9 confirmed that the facility failed to properly screen NA Employee E19, and LPN Employee E20 by completing a certification/license check prior to hire, as required. 28 Pa Code: 201.14(a) (c)(d)(e) Responsibility of licensee 28 Pa Code: 201.19 Personnel policies and procedures 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development 28 Pa Code 201.18(b)(1)(2)(e)(1) Management.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for one of five residents (Residents R26). Findings include: Review of facility policy Conducting an Accurate Resident assessment dated [DATE], indicated the purpose is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. 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 2025, indicated the following instructions: N0415G1, Diuretic: check if a diuretic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). O0110K1, Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of the clinical record revealed Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's MDS dated [DATE], indicated diagnoses of anemia (too little healthy red blood cells), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression. Section N0415G1 was not selected, indicating the resident did not receive a diuretic during the 7-day look-back period. Section O0110K1 (Hospice care) was coded no, indicating that the resident did not receive any hospice care during the 14-day assessment period. Review of a physician order dated 3/19/25, indicated to administer Lasix (a diuretic medication used to prevent the body from absorbing too much salt, used to treat fluid retention) 40 milligrams by mouth one time a day for congestive heart failure. Review of Resident R26's Medication Administration Record (MAR) For December 2025, indicated the resident received their Lasix medication as ordered. Review of a physician order dated 3/28/25, indicated to admit to hospice services 3/18/25, admitting diagnosis congestive heart failure. During an interview on 2/12/26, at 1:06 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E13 confirmed Resident R26's MDS dated [DATE], was coded incorrectly and should have reflected the resident's diuretic therapy and hospice care. During an interview on 2/12/26, at 1:06 p.m. RNAC Employee E13 confirmed that the facility failed to ensure Minimum Data Set assessments accurately reflected the resident's status for one of five residents (Residents R26). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review facility policies, observations, clinical records, and staff interviews, it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of an indwelling urinary catheter (closed sterile system inserted into the bladder to allow for urine drainage) as required for two of three residents (Resident R34 and R88). Findings include: Review of facility policy Resident Rights last reviewed 12/11/25, indicated the resident has a right to a dignified existence. The resident has a right to personal privacy. Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE]. Review of Resident R34's MDS dated [DATE], indicated diagnoses of hyperlipidemia (high fat in the blood), anxiety and urinary retention (bladder doesn't empty completely). Review of Resident R34's physician orders dated 2/1/26, indicated catheter/foley size 18 french with 10 cubic centimeter (cc) balloon. During an observation completed on 2/9/26, at 11:12 a.m. Resident R34 was lying in bed with a catheter connected to a drainage bag, the drainage bag failed to be covered as required. During an interview completed on 2/9/26, at 11:21 a.m. Registered Nurse Employee E5 confirmed the drainage bag failed to be covered as required. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE], with diagnosis of infection and inflammatory reaction due to internal right hip prosthesis (device that replaces damaged hip joints), anemia (low iron in the blood) and anxiety. During an observation completed on 2/9/26, at 11:43 a.m. Resident R88 was lying in bed with a catheter connected to a drainage bag, the drainage bag failed to be covered as required. During an interview completed on 2/9/26, at 11:45 a.m. Licensed Practical Nurse Employee E2 confirmed Resident R88's drainage bag was not covered as required. Review of Resident R88's physician orders dated 2/7/26, indicated Catheter- Type (specify) French (specify) diagnosis (specify) every shift for catheter care. During an interview completed on 2/11/26, at 9:57 a.m. Registered Nurse (RN) Employee E13 confirmed Resident R88's physician orders did not specify the type of catheter, the size of the catheter, the diagnosis for use of the catheter or the amount of sterile water needed for the inflation of the catheter balloon (holds catheter in place in the bladder) and that the facility failed to make certain that appropriate treatments and services were provided for the use of an indwelling urinary catheter (closed sterile system inserted into the bladder to allow for urine drainage) as required for two of three residents (Resident R34 and R88). 28 Pa Code 201. 18(b)(1) Management. 28 Pa Code: 211.10(c)(d) Resident care policies. 28 Pa Code: 211.12(c)(d)(1)(2)(5) Nursing services		

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NAME OF PROVIDER OR SUPPLIER Rochester Residence and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 174 Virginia Avenue Rochester, PA 15074	
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to provide adequate treatment and care for a midline catheter (a thin flexible tube inserted into a vein in the upper arm with the tip positioned just below the armpit) for one of two residents (Resident R5). Findings include: Review of Resident R5's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - periodic assessment of care needs) dated 11/11/25, indicated diagnoses of anemia (low iron in the blood), heart failure (heart doesn't pump the way it should) and hypertension (high blood pressure). Review of physician orders dated 2/3/26, at 6:00 pm indicated Sodium Chloride Solution 0.9 % (a supplemental fluid used for hydration) at 100 milliliters (ml)/ hour (hr) intravenously (IV-administering fluids or medications directly through a vein) for 24 hours. Review of physician orders dated 2/3/26, at 6:45 p.m. indicated Midline placement for Intravenous (IV) fluids one time. Review of Resident R5's progress note dated 2/5/26, at 8:35 p.m. indicated midline in upper right arm without signs or symptoms of infection/infiltration. Review of Resident R5's progress note dated 2/7/26, at 5:52 a.m. indicated client is resting in bed, c/o abdominal discomfort, client has finished fluids right midline is patent and flushes easily. Review of Resident R5's progress note dated 2/8/26, at 4:01 a.m. indicated right midline patent and flushes easily no signs or symptoms of infiltration. During an observation completed on 2/9/26, at 11:51 a.m. Resident R5 was lying in bed a midline in his right upper arm. The cover dressing was dated 2/3/26. During an interview and observation completed on 12/12/26, at 10:07 a.m. Registered Nurse RN Employee E16 confirmed the midline was in place and dated 2/3/26. During an interview completed on 2/12/26, at 10:20 a.m. upon asking RN Employee E13 concerning care for Resident R5's midline stated, there are no orders for flushes or dressing changes and confirmed the facility failed to provide adequate treatment and care for a midline catheter for one of two residents (Resident R5). 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluation at least once every 12 months for one of three nurse aide (NA) personnel records (NA Employee E28). Findings include: Review of NA Employee E28's personnel record indicated a hire date of 10/18/23. Review of NA Employee E28's personnel records revealed that the latest performance evaluation was conducted on 1/8/24. During an interview on 2/12/25, at 12:11 a.m. the Human Resources Employee E9 confirmed that there was not a performance evaluation conducted in the year 2025 for NA Employee E28, and the facility failed to complete annual performance evaluation at least every 12 months for NA Employee E28 as required. 28 Pa Code: 201.14 (b) Responsibility of licensee28 Pa Code: 201.18 (b)(1)(3) Management		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of three residents reviewed (Resident R55). Findings include: Review of facility policy Dementia Care dated 12/11/25, indicated the facility will 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, mental, and psychosocial well-being. The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals. The care plan interventions will be related to each resident's individual symptomatology and rate of dementia (or related disease) progression with end result being noted improvement or maintained of the expectation stable rate of decline associated with dementia and dementia-like illnesses. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record revealed Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/27/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question C0500 BIMS Summary Score indicated the resident scored a 8, moderately impaired. Review of Resident R7's care plan on 2/12/26, failed to indicate the facility had developed and implemented an individualized person-centered care plan to address Resident R55's dementia and cognitive loss. During an interview on 2/12/26, at 2:15 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E13 confirmed that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of three residents reviewed (Resident R55). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Effective Communication for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum Effective Communication. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include Effective Communication training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include Effective Communication training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on Effective Communication for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff Development.		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Resident Rights for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum Resident Rights. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include Resident Rights training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include Resident Rights training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on Resident Rights for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum Abuse, Neglect, and Exploitation Prevention. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include Abuse, Neglect, and Exploitation training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include Abuse, Neglect, and Exploitation training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum QAPI program. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include QAPI program training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include QAPI program training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on QAPI program for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Infection Control for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum Infection Prevention, and Control Program. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include Infection Control training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include Infection Control training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on Infection Control for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Compliance and Ethics for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum Compliance and Ethics Program. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include Compliance and Ethics training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include Compliance and Ethics training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on Compliance and Ethics for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Behavioral Health for two of five staff members (Registered Nurse (RN) Employee E29, and E30). Findings include: Review of facility policy Training Requirements dated 12/11/25, indicated that it is the policy of this facility to develop, implement and maintain an effective training program for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program, Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. Training content includes at a minimum Behavioral Health. Review of RN Employee E29's personnel file indicated a hire date of 2/1/24, and failed to include Behavioral Health training between 2/1/25, and 2/1/26. Review of RN Employee E30's personnel file indicated a hire date of 12/28/23, and failed to include Behavioral Health training between 12/28/24, and 12/28/25. During an interview on 2/12/25, at 12:11 a.m. Human Resources Employee E9 confirmed that the facility failed to provide training on Behavioral Health for two of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.		