STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395751	A. Building B. Wing	06/07/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46336 Based on observation, and staff interview, it was determined that the facility failed to maintain a clean, safe, and homelike environment in six of six resident rooms, one of two shower rooms and one of three hallways (Residents R2, R6, R11, R25, R36, R43 and Fourth-floor shower room, Fourth-floor hallway be elevator). Findings Include: Review of the facility policy Safe and Homelike Environment dated 5/31/24, indicated in accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Review of the admission record indicated R6 admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/26/24, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), hypertension (high blood pressure) and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs). Observation on 6/3/24, at 9:59 a.m. indicated Resident R6's bedside table had smooth surface removed exposing particle board that was corroded with brown/green sticky substance with food particles stuck in it. Interview on 6/3/24, at 10:05 a.m. Licensed Practical Nurse (LPN) Employee E17 confirmed the appearance of Resident R6's bedside table and that it was not clean or safe for the resident's use. Review of the admission record indicated Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's MDS dated [DATE], indicated the diagnoses of hypertension, arthritis, and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Observation on 6/3/24, at 10:19 a.m. Resident R11's room had the door bed removed and gray cement showing at the base of the blue wall. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/3/24, at 10:19 a.m. Resident R11 indicated her roommate passed away several weeks ago and they removed the bed then and never brought it back in. Interview on 6/4/24, at 9:45 a.m. Housekeeping Employee E18 confirmed the appearance of the wall and that the bed was not present. Observation on 6/3/24, at 10:21 a.m. the Fourth-floor shower room single shower stall's drain was clogged with hair and debris. Interview on 6/3/24, at 10:22 a.m. Nurse Aide (NA) Employee E16 confirmed the drain was not clean and clogged with hair and debris. Observation on 6/3/24, at 12:27 p.m. the hallway beside the elevator had a maintenance cart that included the following supplies which were unlocked and unattended: a drill with a drill bit in place, a box of metal screws, and multiple screwdrivers. Interview on 6/3/24, at 12:29 p.m. NA Employee E5 confirmed the supplies were not safe as they were not locked and unattended. Review of Resident R25's MDS dated [DATE], indicated admission to facility on 1/1/23, with the diagnosis of anxiety, depression, and dementia. Observation 6/3/24, at 10:22 a.m. Resident R25 was in bed, a [NAME]-colored floor mat was on the floor to the left side of bed. The mat appeared stained/dirty and was ripped on the edges. Interview 6/3/24, at 10:24 a.m. certified occupation therapist assist (COTA) Employee E15 confirmed Resident R25's floor mat was stained/dirty and ripped on edges. Review of admission record indicated Resident R43 was admitted to facility on 9/22/23, with the diagnosis of hemiplegia (one sided paralysis or weakness), hypertension, and dementia. Observation 6/3/24, 10:30 a.m. Resident R43 was in bed a [NAME]-colored floor mat was on the left side of the bed, the mat was frayed around the edges and visibly soiled. Interview 6/3/24, at 10:32 a.m. Registered Nurse (RN) Employee E14 confirmed Resident R413's [NAME]-colored floor mat was frayed around the edges and visibly soiled. Review of Resident R36's MDS dated [DATE], indicated admitted [DATE], with the diagnosis of anxiety, depression, and dementia. Observation 6/3/24, at 11:10 a.m. a [NAME]-colored floor mat on the right side of Resident R36's bed was frayed around the edges and visibly soiled. Interview on 6/3/24, at 11:12 a.m. RN Employee E11 confirmed Resident R36's [NAME]-colored floor mat was frayed around the edges and visibly soiled. Review of Resident R2's MDS dated [DATE], indicated admitted [DATE], with the diagnosis of atrial fibrillation (abnormal heart rhythm), heart failure, and hypertension. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 6/3/24, at 11:14 a.m. a blue floor mat to the right side of Resident R2's bed with torn edges and foam visibly sticking out. Interview 6/3/24, at 11:17 a.m. RN Employee E11 confirmed Resident R2's blue floor mat had torn edges and foam was sticking out of it. Employee E11 picked up the mat to look closer and stated, the zipper is broken that is why the foam is sticking out. Interview on 6/5/24, at 10:15 a.m. the Nursing Home Administrator confirmed the facility failed to maintain a clean, safe, and homelike environment in six of six resident rooms, one of two shower rooms and one of three hallways (Residents R2, R6, R11, R25, R36, R43 and Fourth-floor shower room, Fourth-floor hallway be elevator). 29 Pa. Code 207.2(2) Administrator's Responsibility. 28 Pa. Code 201.29(j) Resident rights.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41984 Based on review of facility documents, resident interviews, meal tray observations and staff interviews, it was determined that the facility failed to provide palatable meals during lunch for two of two meal observations (Lunch on 6/3/24 and 6/4/24). Findings include: During lunch observations on 6/3/24, at 12:45 p.m. of the fourth floor dining room, the drink cooler revealer twelve out of twelve apple juice containers that were frozen. Hot tea and coffee were served out of foam cups. During lunch observations on 6/3/24, at 1:25 p.m. Resident R94 lunch tray found a salad with French fries appearing not fully cooked. During an interview on 6/3/24, at 1:25 p.m. Resident R94 stated I have frozen pudding and the salad is frozen cold! During an interview on 6/3/24, at 1:31 p.m. Registered Nurse (RN) Employee E6 stated: Resident R94's French fries do not look done and her apple juice is frozen. During a resident council group interview on 6/5/24, at 1:59 p.m. two out of four residents stated that the food is tasted bad. During an interview on 6/6/24, at 10:30 a.m. Dietary Manager Employee E3 confirmed the food palatability issues. 28 Pa. Code: 201.29(d) Resident Rights. 28 Pa. Code: 211.6(a) Dietary 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** 46336 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for six of six months (January 2024 - June 2024), failed to implement enhance barrier precautions for one of three residents (Residents R27), failed to prevent cross contamination during a dressing change for one of three residents (Resident R27), failed to prevent cross contamination during a medication pass for two of three residents (Residents R33, R47), failed to have appropriate isolation signage posted for one of three residents (Resident R88), failed to utilize soiled utility area appropriately, and failed to provide evidence of control measures and testing protocols for water management prevention program for six of six months (January 2024 -June 2024). Findings include: Review of the facility policy Infection Prevention and Control Program dated 5/31/24, indicated the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines, to include a system of surveillance. Water management control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current Centers for Disease Control and Prevention (CDC) guidelines. Review of the Enhanced Barrier Precautions in Skilled Nursing Facilities - Course Number WC4446 from the Center for Disease Control and Prevention (CDC) dated November 2022, indicated enhanced barrier precautions (EBP) are in place for residents with an infection or colonization of a multi-drug resistant organism (MDRO), wounds and/or indwelling medical devices, such as an indwelling catheter, trach/vent, central line, and feeding tube. Gowns and gloves are to be on before entering residents' rooms and used when providing high contact care with a resident who is in EBP. Review of facility policy Clean Dry Dressing dated 5/31/24, indicated to cleanse the wound as ordered, wash/sanitize hands and put on clean gloves before applying topical ointments or creams and dressing the wound as ordered. Review of the facility policy Medication Administration dated 5/31/24, indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review of the facility policy Soiled Linen and Trash Containers dated 5/31/24, indicated Soiled utility rooms shall be used for storing soiled linen and trash. The room should be identified as hazardous areas with the appropriate protections (signage, self-closing doors). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Infection Control documentation for the previous six months (January 2024 - June 2024), failed to reveal surveillance for tracking infections for residents for months January 2024 - June 2024. During an interview on 6/4/24, at 9:00 a.m. infection control documentation was requested from Regional Nursing Home Administrator (NHA) Employee E20 who indicated the facility's Infection Preventionist was not present in the facility. During an interview on 6/4/24, at 1:07 p.m. Regional NHA Employee E20 provided the infection control documentation and the facility had trending but confirmed there was not floor plan surveillance from January 2024 - June2024. Review of the facility's water management book 6/7/24, at 9:31 a.m. indicated the facility failed to document preventative measures to prevent Legionella growth and/or other opportunistic waterborne pathogens in the facility's water systems based on nationally accepted standards from January 2024 - June 2024. During an interview on 6/7/24, at 9:45 a.m. the NHA confirmed the facility failed to document preventative measures to prevent Legionella growth and/or other opportunistic waterborne pathogens in the facility's water systems based on nationally accepted standards from January 2024 - June 2024. Review of the admission record indicated Resident R27 was admitted to the facility on [DATE]. Review of Resident R27's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/20/24, indicated the diagnoses atrial fibrillation (an irregular heart rhythm), high blood pressure, and seizure disorder (a person experiences abnormal behaviors, symptoms, and sensations, sometimes including loss of consciousness). Review of Resident R27's physician order dated 5/31/24, indicated Enhanced Barrier Precautions (EBP) related to wounds. Review of Resident R27's care plan dated 5/31/24, indicated EBP related to wounds. Observation of Resident R27's room on 6/4/24, indicated the facility failed to have signage of EBP on the doorway, and failed to have gloves and gowns available at entrance of room. Review of Resident R27's physician order 5/31/24, indicated to clean left lateral calf with normal saline (wound cleanser) apply skin prep (barrier for skin) to around the wound, Medihoney (wound treatment gel) to open wound area and cover with gauze. Observation of Resident R27's dressing change on 6/5/24, at 9:23 a.m. Licensed Practical Nurse (LPN) Employee E19 made the following cross contamination opportunities and failed to wear a gown during direct wound care as per EBP standards: -LPN Employee E19 double gloved her right hand, removed the soiled dressing with her right hand, pulled the second glove off her right hand with her gloved left hand, did not wash her hands and proceeded to cleanse the wound. Next, she squeezed the tube of Medihoney on to her fingers and applied to the wound bed directly. LPN Employee E19 confirmed the discrepancies and indicated she doubled gloved and didn't think she had to rewash her hands after removing the second glove. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/25/24, indicated admitted [DATE], with the diagnosis of anemia (low iron in the blood), atrial fibrillation (abnormal heart rhythm), and hypertension (high blood pressure). Review of Resident R33's physician orders dated 6/5/24 indicated Voltaren external gel 1 % (Diclofenac Sodium (Topical) Apply to right knee topically every 8 hours as needed for pain. Physician order dated 6/6/24, indicates Norco Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. Observation 6/5/24, at 9:00 a.m. Registered Nurse (RN) Employee E12, was preparing medications for Resident R33, while dispensing the Norco, the pill missed the medication cup and landed on the med cart. RN Employee E12 picked the Norco pill off the top of the medication cart with bare hands and placed in the medication cup, RN Employee E12 then removed a tube of Voltaren gel from the right pocket of her scrub jacket and proceeded into Resident R33's room. RN Employee E12 administered the Norco pill, Resident R33 declined the Voltaren gel at this time. Interview 6/5/24, at 9:16 a.m. RN Employee E12 confirmed the above and stated, if the Norco would have fallen on the floor, I would have wasted it, the narcotic count is always off, which is why I did not want to waste it, I am afraid it would bring suspicion to me. RN Employee E12 also confirmed the Voltaren gel was stored in her right scrub jacket pocket for convenience as resident usually request the medication to be applied. Review of Resident R47's clinical record indicates an admitted [DATE], with the diagnosis of chronic pain, atherosclerosis (thickening or hardening of arteries caused by a buildup of plaque in the inner lining), and schizophrenia (mental health condition that affects how a person thinks, feels, and behaves). Review of Resident R47's physician orders dated 5/3/24, indicates Citalopram oral tablet 20 mg one time a day. Observation 5/5/24, at 8:33 a.m. RN Employee E12 was preparing medications for Resident R47, the Citalopram missed the medication cup and fell on the floor. RN Employee E12 picked the Citalopram off the floor, discarded the pill, and continued the medication pass without sanitizing or washing her hands. Interview 6/5/24, at 9:16 a.m. RN Employee E12 confirmed picking the pill off the floor and not sanitizing or washing her hands before continuing the medication pass. Review of the admission record indicated Resident R88 admitted to the facility on [DATE]. Review of Resident R88's MDS dated [DATE], indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), high blood pressure, and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Observation on 6/3/24, at 10:43 a.m. Resident R88's door had a sign which indicated contact precautions. (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 interview on 6/3/24, at 10:44 a.m. LPN Employee E19 indicated Resident R88 was covid positive, but the sign should have been removed. Only contact remained on the door, but if she was covid positive she should have had a droplet sign up and a contact sign up. They must have left the contact on the door by mistake. Interview on 6/3/24, at 11:00 a.m. Survey Agency (SA) asked LPN Employee E17 where the residents' snacks were kept. Observation on 6/3/24, at 11:01 a.m. LPN Employee E17 unlocked a door labeled Soiled Utility, behind which was a hallway with an odor, a soiled utility room to the right of the doorway that did not have a door, and the snack cart stored in the hallway. Interview on 6/3/24, at 11:01 a.m. LPN Employee E17 confirmed the snacks should not be stored in the soiled utility area. Interview on 6/7/24, at 9:31 a.m. the NHA confirmed the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for six of six months (January 2024 - June 2024), failed to implement enhance barrier precautions for one of three residents (Residents R27), failed to prevent cross contamination during a dressing change for one of three residents (Resident R27), failed to prevent cross contamination during a medication pass for two of three residents (Residents R33, R47), failed to have appropriate isolation signage posted for one of three residents (Resident R88), failed to utilize soiled utility area appropriately, and failed to provide evidence of control measures and testing protocols for water management prevention program for six of six months (January 2024 -June 2024). 28 Pa. Code: 201.29(i) Resident Rights. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. 28 Pa. Code: 201.14 (a) Responsibility of licensee.