STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305081	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Healthcare Center	62 Rochester Hill Road Rochester, NH 03867

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37488 Based on interview and record review, it was determined that the facility failed to ensure that a resident's right to leave the nursing home for activities was protected for 1 of 2 residents reviewed for resident rights. (Resident identifier is #2.) Findings include: Review on 9/15/22 of Resident #2's active physician orders revealed an order dated 8/29/22 that stated No LOA [Leave of Absence] allowed for patient safety at this time. Review on 9/15/22 of Resident #2's medical record revealed that Resident #2's daughter was the appointed guardian over Resident #2. Interview on 9/15/22 at approximately 1:50 p.m. with Staff C (Director of Nursing) confirmed that Staff E (Medical Director) had written an order that stated Resident #2 could not go on LOA from the facility. Staff C stated that there was no communication with Resident #2's guardian about Resident #2 not being allowed to go on LOA with the guardian or family. Interview on 9/15/22 at approximately 4:20 p.m. with Resident #2 revealed that Resident #2 verbalized that she/he was very involved with family and was very appreciative that they took Resident #2 out for visits. Resident #2 stated that she/he misses going out with family and started crying. Interview on 9/19/22 at approximately 9:18 a.m. with Resident #2's guardian revealed that Resident #2 informed the family that Staff E wrote an order stating that Resident #2 was not allowed to go on LOA related to safety concerns. Resident #2's guardian stated they provide a safe environment when Resident #2 visits. Resident #2's guardian confirmed that she/he was not notified of this order by the facility or by Staff E. Interview on 9/16/22 at approximately 11:30 a.m. with Staff E confirmed the above mentioned physician order was written by Staff E for safety concerns. Staff E stated that he/she has not discussed the above mentioned physician order with Resident #2's guardian.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43408 Based on interview and record review, it was determined that the facility failed to ensure that alleged violations of abuse were reported to the State Survey Agency within 24 hours for 2 of 3 residents reviewed for abuse. (Resident identifiers are #1, and #2.) Findings include: Resident #1 Review on 9/15/22 at approximately 10:00 a.m. of Resident #1's nursing notes revealed the following: On 8/18/22 at 1:21 a.m. Resident heard yelling from room for help, unwitnessed fall, Resident was found down on the bathroom floor without injury. Transferred from floor to WC [wheelchair] to bed without incident. Resident comfortable. On 8/18/22 at 4:30 a.m. Post unwitnessed fall earlier this am [morning], Resident c/o [complained of] discomfort over 3 hours, progressively worsening, also c/o testicular pain that had also started after [pronoun omitted] unwitnessed fall. Resident discussed going to hospital for evaluation and possible treatment. Resident and this nurse agree. EMS [Emergency Medical Services] dispatched and resident transported to [facility name omitted] with no further incident . Interview on 9/15/22 at approximately 12:00 p.m. with Staff A (nurse) revealed that Resident #1 had fallen on 8/8/22 as well as 8/18/22. Staff A stated that on 8/18/22 Resident #1 was found in the bathroom on the floor, nothing abnormal was noted with a visual assessment for injury and proceeded to get other staff to assist with getting Resident #1 off the floor and back to bed. Staff A did not recall if the provider was notified at the time of the fall. Staff A also stated that they had gone back into check on Resident #1 noted the pain, administered Acetaminophen and when they went back to check effectiveness they noted Resident #1 was still in pain and that is when they called to have Resident #1 transported to the hospital and notified the family. Interview with Staff A also revealed that the on 8/8/22, Staff A found Resident #1 on the floor by the bed unresponsive and what appeared to be foam coming out of their mouth. Staff A called 911 and had Resident #1 sent to the hospital. Staff A stated they did not notify the provider as they were not aware they needed to do so until later. Review on 9/16/22 at approximately 10:00 a.m. of the Physical therapy assessment summary documented on 8/18/22 revealed .Nursing reported pt [patient] experienced unwitnessed fall morning of 8/18/22 and was transferred to hospital for further evaluation. Pt [patient] was admitted to hospital due to LE [lower extremity] fracture per nsg [nursing] f/u [follow up] late AM [morning]. Interview on 9/16/22 at approximately 11:00 a.m. with Staff C (Director of Nursing) stated that no reports to the State Survey Agency were completed for Resident #1. Resident #2 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 9/15/22 of Resident #2's podiatry note dated 8/18/22 revealed that Resident #2's right hallux had mild edema (swelling), erythema (redness) along distal half of digit, positive tenderness with palpation especially along distal tip of toe, no open lesions, positive calor was noted on right great toe. Further review of the podiatry note revealed a recommendation to X-Ray right foot in the following views: AP [Anteroposterior], Lateral, Oblique of right foot and Up-close of Right great toe in AP and Lateral view; Obtain X-Ray report. Review on 9/15/22 of Resident #2's medical record revealed a radiology results report dated 8/19/22 that revealed an acute fracture involving the right 5th proximal phalanx with minimal displacement. Interview on 9/15/22 at approximately 1:50 p.m. with Staff C (Director of Nursing) confirmed the above findings. Staff C stated that the above mentioned fracture was an injury of unknown origin. Staff C also stated that this injury of unknown origin was not reported to the LTC (Long Term Care) Ombudsman and Survey State Agency. Review on 9/16/22 of facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revised on 8/1/22, revealed .4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. B. Abuse: .d. injuries of unknown source: includes circumstances when both the following conditions are met; i. The source of the injury was not observed by any person or could not be explained by the resident. ii. The injury is suspicious because of the extent of the injury, location of injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time .8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences .2. The Director of Nursing Services, Administrator, or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after the discovery or forming the suspicion .3. The Administrator should follow up with government agencies, during business hours, to confirm the report was received and to report the results of the investigation when final as required by state agencies .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46510 Based on interview and record review, it was determined that the facility failed to ensure that alleged violations of abuse were thoroughly investigated to prevent further potential abuse and neglect for 3 of 3 residents reviewed for abuse. (Resident identifiers are #1, #2, and #3.) Findings include: Resident #1 Review on 9/15/22 at approximately 10:00 a.m. of Resident #1's nursing notes revealed the following: On 8/18/22 at 1:21 a.m.Resident heard yelling from room for help, unwitnessed fall, Resident was found down on the bathroom floor without injury. Transferred from floor to WC [wheelchair] to bed without incident. Resident comfortable. On 8/18/22 at 4:30 a.m. Post unwitnessed fall earlier this am [morning], Resident c/o [complained of] discomfort over 3 hours, progressively worsening, also c/o testicular pain that had also started after [pronoun omitted] unwitnessed fall. Resident discussed going to hospital for evaluation and possible treatment. Resident and this nurse agree. EMS [Emergency Medical Services] dispatched and resident transported to [facility name omitted] with no further incident . Interview on 9/15/22 at approximately 12:00 p.m. with Staff A (nurse) revealed that Resident #1 had fallen on 8/8/22 as well as 8/18/22. Staff A stated that on 8/18/22 Resident #1 was found in the bathroom on the floor, nothing abnormal was noted with a visual assessment for injury and proceeded to get other staff to assist with getting Resident #1 off the floor and back to bed. Staff A did not recall if the provider was notified at the time of the fall. Staff A also stated that they had gone back into check on Resident #1 noted the pain, administered Acetaminophen and when they went back to check effectiveness they noted Resident #1 was still in pain and that is when they called to have Resident #1 transported to the hospital and notified the family. Further interview with Staff A revealed that on 8/8/22, Staff A found Resident #1 on the floor by the bed unresponsive and observed what appeared to be foam coming out of their mouth. Staff A called 911 and had Resident #1 sent to the hospital. Staff A stated they did not notify the provider as they were not aware they needed to do so until later. Interview on 9/16/22 at approximately 11:30 a.m. with Staff C (Director of Nursing) confirmed that there was no investigation conducted for Resident #1's fall on 8/8/22 and 8/18/22. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 9/16/22 of facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revised on 8/1/22, revealed .4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. B. Abuse: .d. injuries of unknown source: includes circumstances when both the following conditions are met; i. The source of the injury was not observed by any person or could not be explained by the resident. ii. The injury is suspicious because of the extent of the injury, location of injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time .6. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response .2. The Director of Nursing Services, Administrator, or designee will: b. Obtain statements from direct care staff . Resident #2 Review on 9/15/22 of Resident #2's podiatry note dated 8/18/22 revealed that Resident #2's right hallux had mild edema (swelling), erythema (redness) along distal half of digit, positive tenderness with palpation especially along distal tip of toe, no open lesions, positive calor was noted on right great toe. Further review of the podiatry note revealed a recommendation to X-Ray right foot in the following views: AP [Anteroposterior], Lateral, Oblique of right foot and Up-close of Right great toe in AP and Lateral view; Obtain X-Ray report. Review on 9/15/22 of Resident #2's medical record revealed a radiology results report dated 8/19/22 that revealed an acute fracture involving the right 5th proximal phalanx with minimal displacement. Interview on 9/15/22 at approximately 1:50 p.m. with Staff C (Director of Nursing) confirmed the above findings. Staff C stated that the above mentioned fracture was an injury of unknown origin. Staff C also stated that they did not conduct an investigation on Resident #2's right toe fracture. Resident #3 Review on 9/15/22 of Resident #3 ' s medical record revealed the following nursing notes: On 7/9/22 at 7:01 p.m. At 1800 [pronoun omitted] from PT [physical therapist] came to report that [pronoun omitted] had just picked up [pronoun omitted] walking up on Rochester St. by [facility name omitted] . On 7/26/22 at 1:21 p.m. Patient [Resident #3] was found at the front entrance door at 1200 [12:00 p.m.]. Patient told the writer of this note that [pronoun omitted] was looking to take a plane to [NAME] NH and from there a plane to California. The writer of this note convinced patient to take a walk back to his familiar wing where patient said [pronoun omitted] agreed to stay another day. Gave patient a snack which calmed patient down. Interview on 9/15/22 at approximately 1:50 p.m. with Staff C (Director of Nursing) confirmed that the facility did not conduct an investigation on Resident #3's elopement on 7/9/22 and 7/26/22.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43408 Based on record review and interview, it was determined that the facility failed to develop and implement a baseline care plan for 1 of 6 residents reviewed for falls. (Resident identifier is #1.) Findings include: Review on 9/15/22 at approximately 10:00 a.m. of Resident #1's medical record revealed that Resident #1 had been initially admitted to the facility on [DATE] and then discharged to the hospital on 8/8/22, readmitted back to facility on 8/16/22 and discharged to the hospital on 8/18/22. Further review of Resident #1's medical record revealed a nursing note that dated 8/18/22 at 1:21 a.m. revealed Resident heard yelling from room for help, unwitnessed fall, Resident was found down on the bathroom floor without injury. Transferred from floor to WC [wheelchair] to bed without incident. Resident comfortable. Interview on 9/15/22 at approximately 12:00 p.m. with Staff A (nurse) revealed that Resident #1 had fallen at the facility on 8/8/22 and 8/18/22, where Resident #1 was discharged to the hospital on both occasions. Review on 9/15/22 of Resident #1's active care plan revealed the only care plans in place were for Diagnosis COPD (chronic obstructive pulmonary disease) / CHF (congestive heart failure) and for emotional state. Further review of the care plan revealed no fall care plan was implemented within 48 hours of Resident #1's initial admission on 8/5/22 and readmission on 8/16/22. Review on 9/16/22 at approximately 11:00 a.m. of Resident #1's Physical Therapy note dated 8/7/22 revealed that .Pt [patient] cooperative during session but poor initiation of requesting staff for transfers in room despite demonstrating I [independence] with call bell use; appears to have dec [decreased] insight into fall risk. PT [physical therapist] updated nursing on pt [patient] transfer status for CGa [contact guard assist]with rw [rolling walker] in room . Review on 9/16/22 of Resident #1's Physical Therapy note dated 8/16/22, revealed that .presenting for [pronoun omitted] skilled rehab [facility name omitted] as [pronoun omitted] was found on the floor . Further review of Physical Therapy notes revealed an entry on 8/16/22 PT [Physical Therapist] assessed pt [patient] for and issued loaner rw [rolling walker] for use with transfers with LNA's [Licensed Nursing Assistants]. Pt [Physical Therapist] initiated pt [patient] education on use of call bell placed within [pronoun omitted] reach; pt [patient] able to verbalize and demonstrate how to use but showed poor carryover with use of call bell to request staff A [assistance] for mobilization to toilet as PT [Physical Therapist] returned to room to issue cushion 1 hr [hour] after eval and observed pt [patient] seated in bathroom on toilet with unlocked wc [wheelchair] by his side no call bell activated. PT [Physical Therapist] educated pt [patient] on plan to trial signage in room to assist pt [patient] with recall of importance to request staff assist for all transfers; 3-11 LNA [Licensed Nursing Assistant] and nurse were updated by PT [Physical Therapist] on recommended transfer status, supervised dining in DR [dining room] as well as high falls risk and need for frequent checks during pm [evening] . (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/16/22 at approximately 11:30 a.m. with Staff C (Director of Nursing) confirmed that Resident #1 had no falls care plans in place. Review on 9/16/22 of facility policy titled Baseline Care Plan, initiated on 2/1/20, revealed The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care . Review on 9/16/22 of facility policy titled Fall Prevention Program, revised on 8/1/21, revealed .3. The nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan .8. When any resident experiences a fall, the facility will: .e. Review the resident's care plan and update as indicated .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43408 Based on record review and interview, it was determined that the facility failed to develop and implement a comprehensive care plan for 1 of 3 residents reviewed for elopement risk. (Resident identifier is #3.) Findings include: Review on 9/15/22 of Resident #3's elopement assessment dated [DATE] revealed a score of 10 out of 15 that indicated that Resident #3 was at risk for wandering. Review on 9/15/22 of Resident #3 's nurse's notes dated 7/9/22 at 7:01 p.m. revealed At 1800 [6:00 p.m.] [pronoun omitted] from PT came to report that [pronoun omitted] had just picked up [pronoun omitted] walking up on [facility name omitted] . Review on 9/15/22 of Resident #3's nurse's notes dated 7/26/22 at 1:21 p.m. revealed Patient [Resident #3] was found at the front entrance door at 1200 [12:00 p.m.]. Patient told the writer of this note that [pronoun omitted] was looking to take a plane to [location ommitted] and from there a plane to [location omitted]. The writer of this note convinced patient to take a walk back to [pronoun omitted] familiar wing where patient said [pronoun omitted] agreed to stay another day. Gave patient a snack which calmed patient down. Review on 9/15/22 of Resident #3's medical record revealed that Resident #3's care plan did not reflect any elopement interventions after initial elopement was identified. Interview on 9/15/22 at approximately 1:45 p.m. with Staff C (Director of Nursing) confirmed that Resident #3's care plan was not updated after initial elopement was identified.

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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 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** 43408 Based on interview and record review, it was determined that the facility failed to provide adequate supervision to prevent a fall which resulted in actual harm that was immediate in which resident sustained a hip fracture and eventual death for 1 of 3 residents reviewed for falls (Resident identifier is #1). The facility also failed to provide adequate supervision to prevent elopement for 1 of 3 residents reviewed for elopement risk. (Resident identifier is #3.) Findings include: Resident #1 Interview on 9/14/22 at approximately 3:36 p.m. with Resident #1's responsible party revealed that Resident #1 fell and broke their hip at the facility and later passed away. Resident #1's responsible party stated that they were told the death was related to the fall with fracture. Review on 9/15/22 of Resident #1's nurse's notes dated 8/18/22 at 1:21 a.m. revealed Resident heard yelling from room for help, unwitnessed fall, Resident was found down on the bathroom floor without injury. Transferred from floor to WC [wheelchair] to bed without incident. Resident comfortable. Review on 9/15/22 of Resident #1's nurse's notes dated 8/18/22 at 4:30 a.m. Post unwitnessed fall earlier this am [morning], Resident c/o [complained of] discomfort over 3 hours, progressively worsening, also c/o testicular pain that had also started after [pronoun omitted] unwitnessed fall. Resident discussed going to the hospital for evaluation and possible treatment. Resident and this nurse agree. EMS [Emergency Medical Services] dispatched and resident transported to [facility name omitted] with no further incident. Daughter was called at 0440 [4:40 a.m.] and made aware of above . Further review of Resident #1's nurses notes revealed no other falls or incidents occurred. Review on 9/15/22 of Resident #1's August 2022 Medication Administration Record revealed that on 8/18/22 at 2:00 a.m. Resident #1 received Acetaminophen extra strength 1000 mg (milligrams) for 4/10 pain. Interview on 9/15/22 at approximately 11:00 a.m. with Staff C (Director of Nursing) confirmed the above information. Staff C stated they were unaware of the outcome of the hospitalization for Resident #1 as they never returned to the facility. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 9/15/22 at approximately 12:00 p.m. with Staff A (nurse) revealed that Resident #1 had fallen at the facility on 8/8/22 and 8/18/22. Staff A stated that on 8/18/22 Resident #1 was found in the bathroom on the floor, nothing abnormal was noted with a visual assessment for injury and proceeded to get other staff to assist with getting Resident #1 off the floor and back to bed. Staff A did not recall if the provider was notified at the time of the fall. Staff A also stated that they had gone back into check on Resident #1 noted the pain, administered Acetaminophen and when they went back to check effectiveness they noted Resident #1 was still in pain and that is when they called to have Resident #1 transported to the hospital and notified the family. Further interview with Staff A revealed that on 8/8/22, Staff A found Resident #1 on the floor by bed unresponsive and observed what appeared to be foam coming out of their mouth. Staff A called 911 and had Resident #1 sent to the hospital. Staff A stated they did not notify the provider as they were not aware they needed to do so until later. Review on 9/15/22 of Resident #1's medical record revealed the following: -Census report revealed that Resident #1's initial admission to facility on 8/5/22, -No documentation of a fall risk assessment for Resident #1 on admission, -Resident #1's hospital discharge summary dated 8/5/22 revealed that Resident #1 was admitted to hospital from home with septic shock, ambulatory status was severely limited due to decreased strength and endurance. -Physical therapy notes dated 8/7/22 revealed that Resident #1 had poor initiation of requesting staff for transfers in room despite demonstrating independence with call bell use. Resident #1 appeared to have decreased insight into fall risk. And that physical therapy updated nursing on Resident #1's transfer status for contact guard assist with rolling walker in room. -No documentation of Resident #1 found on floor unresponsive and was sent to hospital on 8/8/22, -No documentation of Resident #1 fall assessments, vital signs, and neurological assessments for 8/8/22 incident, -Census report revealed that Resident #1 was discharged out of the facility on 8/8/22, -Census report revealed that Resident #1 was readmitted to the facility on [DATE], -Resident #1's hospital discharge summary dated 8/16/22 revealed that reason for 8/8/22 admission to hospital was septic shock and acute metabolic encephalopathy, -Resident #1's Morse Fall Scale dated 8/16/22 revealed that Resident #1 has history of falls, Resident #1 required cane or walker for ambulation, Resident #1 exhibited weak gait, Resident #1 was forgetful of own safety limits, -Physical therapy note dated 8/16/22 revealed that nurses were updated by physical therapist on recommended transfer status as well as high fall risk and need for frequent checks during evening. -Nurse's notes revealed that Resident #1 was found on floor on 8/18/22 as mentioned above, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305081	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Healthcare Center	62 Rochester Hill Road Rochester, NH 03867

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	-No documentation of Resident #1's vital signs and neurological assessments for 8/18/22 unwitnessed fall, -Census report revealed that Resident #1 was discharged out of the facility on 8/18/22, -Physical therapy assessment note dated 8/18/22 revealed that nursing reported that Resident #1 experienced an unwitnessed fall morning of 8/18/22 and was admitted to the hospital due to lower extremity fracture. -Resident #1's care plan revealed that the only care plans in place were for Diagnosis COPD (chronic obstructive pulmonary disease) / CHF (congestive heart failure) and for emotional state. Further review of Resident #1's medical records revealed no plan of care for adequate supervision to prevent falls. Review also revealed no documentation of frequent checks related to physical therapy recommendations. Interview on 9/16/22 at approximately 10:30 a.m. with Staff D (Licensed Nursing Assistant) revealed that on 8/18/22 they went to Resident #1's room to assist with fall. Staff D stated that Resident #1 was on the floor and at the nurse's direction, 4 staff assisted Resident #1 off the floor to the wheelchair and then back to bed. Interview on 9/16/22 at approximately 11:30 a.m. with Staff C confirmed that Resident #1 had no fall care plan to adequately supervised Resident #1 to prevent falls. Review on 9/16/22 of Resident #1's Certificate of Death revealed, .Cause of Death a. complications of left hip fracture .Describe how injury occurred fall from stand height . Review on 9/16/22 of facility policy titled Falls Prevention Program, revised on 8/1/22, revealed the following: .3. the nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan in accordance with the resident's level of risk .8. When any resident experiences a fall , the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury . 46510 Resident #3 Review on 9/15/22 of Resident #3's elopement assessment dated [DATE] revealed a score of 10 out of 15 that indicated that the Resident #3 was at risk for wandering. Review on 9/15/22 of Resident #3's nurse's note dated 7/9/22 at 7:01 p.m. revealed At 1800 [6:00 p.m.] [pronoun omitted] from PT [physical therapists] came to report that [pronoun omitted] had just picked up [pronoun omitted] walking up on Rochester St. by [facility name omitted] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305081	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Healthcare Center	62 Rochester Hill Road Rochester, NH 03867

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review on 9/15/22 of Resident #3's nurse's note dated 7/26/22 at 1:21 p.m. revealed Patient [Resident #3] was found at the front entrance door at 1200 [12:00 p.m.]. Patient told the writer of this note that [pronoun omitted] was looking to take a plane to [NAME] NH and from there a plane to California. The writer of this note convinced patient to take a walk back to [pronoun omitted] familiar wing where patient said [pronoun omitted] agreed to stay another day. Gave patient a snack which calmed patient down. Review on 9/15/22 of Resident #3's medical record revealed that no elopement interventions were in place after initial elopement risk was identified. Interview on 9/15/22 at approximately 1:40 p.m. Staff C confirmed that there were no interventions put in place after the elopement on 7/26/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305081	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Healthcare Center	62 Rochester Hill Road Rochester, NH 03867

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46510 Based on interview and record review, it was determined that the facility failed to ensure that resident's records were complete and accurate for 1 out of 3 residents reviewed for falls. (Resident identifiers are #1.) Findings include: Resident #1 Review on 9/15/22 of Resident #1's medical record revealed a nurse's notes dated 8/18/22 at 1:21 a.m. revealed that Resident heard yelling from room for help, unwitnessed fall, Resident was found down on the bathroom floor without injury. Transferred from floor to WC [wheelchair] to bed without incident. Resident comfortable. Further review of Resident #1's medical record revealed no other falls or incidents occurred in the month of August 2022. Interview on 9/15/22 at approximately 12:00 p.m. with Staff A (nurse) revealed that Resident #1 had fallen at the facility on 8/8/22 and 8/18/22. Staff A stated that on 8/8/22, Staff A found Resident #1 on the floor by bed unresponsive and observed what appeared to be foam coming out of their mouth. Staff A called 911 and had Resident #1 sent to the hospital. Staff A stated they did not notify the provider as they were not aware they needed to do so until later. Interview on 9/16/22 at approximately 11:30 a.m. with Staff C (Director of Nursing) confirmed that Resident #1's medical record did not reflect any information regarding an incident on 8/8/22. Review on 9/16/22 of facility policy titled Documentation in Medical Record, revised on 3/29/22, revealed . Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress though complete, accurate, and timely documentation .2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred .