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	03/30/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 46336 Based on facility policy review, clinical and facility record review, facility provided documents, hospital records, and staff interviews, it was determined that the facility failed to provide adequate supervision for two residents resulting in elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge). This failure created an immediate jeopardy situation for 10 of 10 residents (Residents R1, R2, R4, R5, R6, R7, R8, R9, R10 and R11) and allowing two of those residents to elope from the 4th floor (Resident R1 and R2). Findings include: Review of facility policy Missing Resident/Elopement Procedures dated 1/26/23, indicated an elopement occurs when a resident leaves a safe area without staff knowledge, or the patient enters an unsafe area without staff knowledge or presence. Review of facility's Wander guard monitoring system test tool dated March 2023, indicated initial every A.M. and P.M. that system is functioning. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, 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 intact 8-12: moderately impaired 0-7: severe impairment Review of the Admission Record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/12/23, indicated the diagnoses of Alzheimer's Dementia (a group of symptoms that affects memory, thinking and interferes with daily life), Legal Blindness (no vision or sees only light, colors or shapes; eyes do not appear to follow objects), and diabetes (too much sugar in the blood). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Section C: Cognitive Patterns, Question C0100 indicated a BIMS score of 3 - severe cognitive impairment. Section D: Mood, Question D0200 indicated resident had feelings of being down, depressed, or hopeless, feeling tired or having little energy, and poor appetite or overeating. Section E: Behavior, Question E0900 Wandering indicated a score of zero, which indicated the behavior was not exhibited. Review of Elopement/Exit Seeking Evaluation Form dated 11/10/22, indicated that Resident R1 had eight of 14 total factors/contributors indicating elopement risk. Review of the clinical record on 3/28/23, failed to include a more recent Elopement/Exit-Seeking Evaluation Form. Review of Resident R1's care plan dated 11/3/22, indicated resident was at risk for elopement/exit-seeking with a goal of remaining safe through next review. Interventions included the following: Anticipate my needs to the extent possible. I will be evaluated on admission and weekly x 3, on a quarterly basis, and with a change of condition. Reassure me when I am distressed. Refer to social services as needed. Use diversional activities when behavior is occurring, i.e. offer companionship, food, activities. Use verbal cues for redirection. Review of Resident R1's physician order dated 11/7/22, indicated wander guard system (equipment to prevent a resident from exiting to an unsupervised and unauthorized location without staff's knowledge) for safety, elopement, and exit-seeking. Check placement and function of wander guard system every eight hours, and to notify supervisor if wander guard is not in place or non-functional. Resident R1's care plan failed to include an intervention regarding the wander guard system. Review of Resident R1's progress notes dated 2/22/23 - 3/18/23, indicated behaviors as follows: 2/22/23 - Resident sitting in hallway talking to himself, states I'm the X-ray technician and I'm here to fix the x-ray machine. 2/23/23 - Resident found on floor in neighboring resident room. 2/24/23 - Physician Employee E1's Progress note references hallucinations (a perception of having seen heard touched, tasted, or smelled something that wasn't actually there) and an increase in falls the past few weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2/27/23 - Haldol (medication to treat mental disorders) ordered to be given at bedtime related to agitation and behaviors; however, did not describe the agitation or behaviors exhibited. 3/16/23 - at 11:54 p.m. Resident restless, ambulating the unit, talking about a dog, escorted to his room by staff who attempted to cover him up with a blanket, resident became agitated, stated staff was insubordinate, that he was the boss, and this was his boat. Resident was found on floor ten minutes later. 3/16/23 - at 2:58 p.m. alert with confusion 3/16/23 - at 9:54 p.m. alert with confusion 3/18/23 - 1:28 p.m. Late entry: resident noted to be in the basement. Staff member from 3rd floor assisted resident to transfer back to the 4th floor where his room is located. Review of facility provided documents, dated 3/23/23, indicated that on 3/18/23, at 1:30 p.m. Nursing Assistant (NA) Employee E2 reported I was approached in the basement and asked if I knew where Resident R1 belonged, as Resident R1 could not recall. NA Employee E2 returned Resident R1 to unit on the fourth floor. Interview on 3/28/23, at 2:00 p.m. NA Employee E2 indicated Somebody approached me on my way back from break in the basement coming to the elevator and said I think he (Resident R1) is lost. NA Employee E2 indicated I knew who it was and took Resident R1 to the fourth floor. He can see some, I guided him. When we got on the elevator in the basement the wander guard activated. I have no idea how Resident R1 got down there. Interview on 3/30/23, at 2:45 p.m. Regional Director of Operations (RDO) Employee E3 indicated the last staff member to last see Resident R1 was NA Employee E4, on the unit shortly after finishing lunch around 1:00 p.m. Telephone interview on 3/30/23, at 2:50 p.m. with NA Employee E4 unsuccessful, a voice message was left and never returned. Review of written statement from NA Employee E5 dated 3/25/23, indicated they did not hear or disable the alarm on 3/18/23 in relation to Resident R1. Review of written statement from NA Employee E6 undated, indicated they did not disable the wander guard system on the elevator on the 11:00 a.m. - 3:00 p.m. shift on 3/18/23. Review of written statement from NA Employee E7 dated 3/18/23, indicated they did not shut wander guard off in the main elevator on 3/18/23 during the daylight shift. Review of written statement from NA Employee E8 undated, indicated on 3/18/23, on the daylight shift they did not disable the wander guard alarm by the elevator. Review of written statement from NA Employee E9 dated 3/24/23, indicated while working the daylight shift on 3/18/23, they did not shut off the wander guard alarm on the main elevator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of written statement from NA Employee E10 dated 3/24/23, indicated they did not hear the alarm go off. They were on break after lunch trays and when they gave care to Resident R1 they didn't see any marks on him. During an observation and interview on 3/28/23, at 10:20 a.m., the Nursing Home Administrator (NHA) stated The vendor was out and discovered the sensitivity of the range was not far enough to reach the lateral edge of the elevator and that's when the wander guard would not lock if a wander guard was near it and that's how we think Resident R1 got downstairs to the basement. Review of Scenic Heights and the Gardens Page 3 of the 24-hour report (a form shared between nursing shifts to share resident information and changes with staff) dated 3/18/23, indicated Registered Nurse (RN) Employee E11 initialed ten of the ten areas where wander guard monitoring devices were located and were functioning. Telephone interview on 3/30/23, at 2:30 p.m. RN Employee E11 indicated We hold a wander guard up to the door and it locks and then an audible alarm. You don't have to open the door. We just hold it up to it. You hold the sensor up to the elevator and an alarm goes off, but it doesn't prevent the elevator from going down. That definitely is not a lock down unit up there, and they have lock down people. It's not enough for that unit. There's only one nurse for the floor. Third or fourth floor staffing is really bad sometimes; days and evening sometimes alone this past Saturday for night shift. If my initials were on the form then I probably checked it before midnight that day, that's when I usually check them. Review of facility's Wander guard monitoring system test tool dated March 2023, indicated the facility failed to test the monitoring system on the following dates for both A.M. and P.M. checks: 3/4/23, 3/19/23, 3/24/23, 3/25/23, 3/26/23, 3/27/23 and 3/28/23. During an interview on 3/30/12, at 11:20 a.m. the NHA confirmed the wander guard system test tool was not consistently completed and could not provide documentation to prove otherwise on the dates listed above. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated the diagnoses Alzheimer's Dementia with severe agitation, paranoid schizophrenia (delusions and hallucinations that blur the line between what is real and what isn't), and atrial fibrillation (irregular heart rhythm). Section C: Cognitive Patterns, Question C0100 indicated a BIMS score of zero - severe cognitive impairment. Section D: Mood, Question D0200 indicated resident was not experiencing symptoms of depression. Section E: Behavior, Question E0900 Wandering indicated a score of zero, which indicated the behavior was not exhibited although behaviors relating to rejection of care were indicated. Review of Elopement/Exit Seeking Evaluation Form dated 3/8/23, indicated that Resident R2 had seven of 14 total factors/contributors indicating elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R2's physician order dated 3/8/22, indicated wander guard system for safety, elopement, and exit-seeking. Check placement and function of wander guard system every eight hours and notify supervisor if wander guard is not in place or non-functional. Review of Resident R2's care plan dated 3/23/23, indicated resident was at risk for elopement/exit-seeking with a goal of remaining safe with a wander guard monitoring system. Interventions included the following: Consent obtained for wander guard. Wander guard monitoring system per facility policy. Resident R2's care plan failed to include interventions relating to exit-seeking and wandering behaviors. Review of Resident R2's progress notes dated 3/12/23 - 3/26/23, indicated behaviors as follows: 3/12/23 - refusal of medication 3/13/23 - Physician Employee E1 progress note worsening dementia and wandering 3/16/23 - minimal responses today with some paranoia 3/17/23 - get out of bed independently to bathroom frequently upsetting roommate by closing the door 3/23/23 - alert with confusion 3/26/23 - NA Employee E12 brought Resident R2 to the 4th floor unit at 3:40 p.m. She was found on the 3rd floor at stairwell. Resident R2 stated she wanted to go to the first floor Villa. Re-directed to room, re-oriented to room and 15-minute checks initiated. Family, Supervisor, and MD notified. Review of written statement from NA Employee E4 dated 3/26/23, indicated at approximately 3:30 p.m. or 3:40 p.m. I was the only aide on the floor and was writing out a work order at the time I saw Resident R2 walk towards her room and around the bend. I did not hear an alarm or anything that would alert me Resident R2 went through the stairwell and I did 15-minute checks afterwards. Interview on 3/28/23, at 9:17 a.m. LPN Employee E19 indicated I took care of Resident R2 a couple times. She'd come out and sit at nurse's station. She seems lost and asks where should she be. She was in 457 door until they moved her. She has dementia and poor memory. Review of facility submitted documents, dated 3/26/23, indicated at approximately 3:40 p.m. NA Employee E12 was approached on level three by Resident R2 who was coming from the back hallway and asked if NA Employee E12 knew how to get to the first floor. The wander guard alarm on level three's back stairwell was alarming which initiated NA Employee E12 to respond. Resident R2 was escorted back to the fourth floor unharmed. Resident R2 was last seen at approximately 3:30 p.m. at the nurse's station on the fourth floor and then observed ambulating toward her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of written statement from NA Employee E12 dated 3/26/23, indicated I was sitting at the nurses' desk around 3:35 p.m. or so charting. While I was sitting there, the alarm for the rear door went off. As I shut it off, I went to go see who it was. Resident R2 came walking from the back hall, walked to the desk asking how to get to the first floor. I instructed Resident R2 to come with me and escorted her to the fourth floor via elevator. The alarm, when we got off the elevator on the fourth floor, did not go off. Review of written statement from RN Employee E14 dated 3/26/23, indicated she just finished getting report a moment prior. She heard the alarm going off. She looked to the left and saw Resident R2 walking towards nursing station on 3rd floor. NA Employee E12 assisted Resident R2 back to unit. The doors on both floors though, open and do not lock, they just easily open. RN Employee E14 indicated she called Maintenance Employee E15 who responded Yeah, we already know and there's nothing we can do about it right now. Review of written statement from RN Employee E16 dated 3/26/23, indicated at approximately 3:40 p.m. NA Employee E12 from the third floor brought Resident R2 up to her unit on the fourth floor and stated Resident R2 set back stairwell alarm off on third floor and was found wandering. Review of written statement from RN Employee E17 dated 3/26/23, indicated NA Employee E12 came to nursing station at 3:40 p.m. and presented Resident R2 to staff at the nursing station on the fourth floor. Resident R2 was observed on the third floor entering via stairwell, Resident R2 stated she wanted to go to the first floor, The Villa (Personal Care floor). Review of written statement from Licensed Practical Nurse (LPN) Employee E18 dated 3/26/23, indicated she came to the fourth floor from third floor to take Hilltop team at 3:30 p.m. At 3:40 p.m. NA Employee E12 brought Resident R2 to nurses' station and stated Resident R2 was observed on third floor entering through stairwell. Interview on 3/28/23, at 9:19 a.m. RN Employee E20 indicated Resident R2 walks with a walker, had recently moved to the 4th floor from the first floor where the personal care home The Villa is located. Resident R2 made it down one floor through the stairs and likely did not have her wheeled walker. RN Employee E20 gave Resident R2 a wander guard the first day she was admitted to the nursing home and nursing checks the batteries, maintenance checks the doors. Interview on 3/28/23, at 11:00 a.m. the NHA indicated At the time, maintenance was called by RN Employee E15, the facility was not aware the mag lock was not engaged, and wander guard system would have worked if bed sled (sleds that slide residents down stairwells) was not depressing the release button. Interview on 3/28/23, at 10:00 a.m. Maintenance Employee E15 indicated This past Sunday I got a call from the facility that the fourth-floor stairwell door was opening without entering a code. They were going to try and do a one-to-one to the doorway. I passed it on to the NHA. The staff didn't mention the wander guard not functioning. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Maintenance Employee E15 continued, The medical sleds for bariatric emergency procedures somehow had removed itself from the anchor on the wall and it was leaning on the mag lock against the exit button, which is why the wander guard did not work, and it disabled the entire thing. They ripped out the small voltage sensor on that door as part of the old system. It would send an alert to the nurse's station that someone went through a fire door without putting in a code. That was disabled back in November. I didn't realize the annunciator was turned off. Interview on 3/30/23, at 3:34 p.m. NA Employee E12 indicated I was at the nurse's station charting and heard the alarm at the back stairwell as it also alarms at the nursing station. I went to see what was going on, NA Employee E12 stated, and here was Resident R2 walking to desk confused, not crying, asking if the stairs go to the first floor. I noticed the wander guard on her arm, confirmed with the nurse that Resident R2 belongs on the fourth floor and escorted her to the nurses' station there. Staff on fourth floor asked where was Resident R2 at? I told them she came down the back stairs. When we got to the fourth floor the elevator alarm did not go off. I told the Assistant Director of Nursing (ADON) Employee E13 and she stated she'd call maintenance. Telephonic interview on 3/29/23, at 1:55 pm with RN Employee E16 unsuccessful, a voice message was left and never returned. Telephonic interview with NA Employee E4 on 3/30/23, at 2:00 p.m. unsuccessful, a voice message was left and never returned. Telephonic interview attempted on 3/30/23, at 2:22 p.m. and 3:00 p.m. with RN Employee E14 was unsuccessful. Wireless caller not available, unable to leave a voice message. Interview on 3/30/23, at 2:47 p.m. LPN Employee E18 indicated I had my coat on to leave, and I heard them saying Resident R2 got through the stairwell. I remember at 8:00 a.m., when I was down by the back stairwell of the fourth floor that day, another resident walking by the exit door, and I heard it click from that resident's wander guard. Interview on 3/30/23, at 3:20 p.m. NA Employee E21 indicated Resident R2 was up four times last night and had to be redirected and the alarms were working then. Interview on 3/30/23, at 3:25 p.m. the NHA confirmed the events of the facility submitted documents and confirmed she did not have a 24-hour report for 3/26/23 to indicate anybody checked the wander guard function that day. Review of facility provided documentation identified that 10 residents wear wander guards and this created an immediate jeopardy situation for 10 of 10 residents (Residents R1, R2, R4, R5, R6, R7, R8, R9, R10 and R11) On 3/29/23, at 1:05 p.m. the NHA and the RDO were made aware that Immediate Jeopardy (IJ) existed for 10 of 10 residents residing of the fouth-floor (Residents R1, R2, R4, R5, R6, R7, R8, R9, R10 and R11). The IJ template was provided to facility administration and a corrective action plan was requested. On 3/29/23, at 2:50 p.m. an acceptable Corrective Action Plan was received which included the following interventions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediate Action: Cited resident from incident dated 3/18/23, is no longer in facility and had no negative outcome from cited incident. This resident was identified as a wander risk and wore a wander guard and was able to bypass existing and functioning wander guard system on elevator due to a small window where the sensor did not reach. Sensitivity has been increased and audits confirm that condition no longer exists as of 3/27/23. Residents: -A review of residents currently living in the center using the Elopement Evaluation will be completed by the Director of Nursing (DON) or designee by 2/28/23, at 3:00 p.m. to identify other residents who are at risk for wandering/exit- seeking. If a current resident is identified as exit-seeking, an alert bracelet will be applied, and care plan updated. Ad Hoc QAPI completed 3/24 Whole house audit was conducted by nurse managers and reviewed by NHA and ADON on elopement risk with updated assessments done on every resident. No further residents identified to be at risk. Wander guards are audited every shift. System correction: Whole house education for all departments including nursing, maintenance, therapy, housekeeping, laundry, dietary, administrative, social services, and activities from SNF including agency and hospice staff was conducted and completed regarding incidents and accidents, reporting incidents via chain of command and to DOH, incident reports, putting interventions in place after incidents/accidents, behavior management, dementia, exit-seeking and wandering, interventions for behaviors and wandering/exit-seeking, elopement protocol including root cause analysis and checking all exits at time of incident, updates on door functioning. Education to include missing person and elopement policy and checklist as updated 2/27/23 and was educated to same group as above. Education was conducted by regional RN or designee via emails, in person meetings and regular mail. In person education was completed on 3/24 through 3/28, with any remaining staff mailed on 3/29. Education is completed. Missing person and elopement policy and checklist was updated on 3/24/23, with revisions completed 3/27/23. Monitoring: Audits of the doors were initiated by Maintenance staff and ADON then continued by RN supervisor to ensure proper functioning for wander guard for elopement risks and locking mechanism for residents not identified as wander risks, with no further issues noted. RN supervisor or designee will continue auditing doors daily x 4 weeks then weekly x 3 months. ADON or designee will audit new admission/returns and quarterly exit-seeking assessments to ensure care plan with appropriate interventions daily x 4 weeks then weekly x 3 months. Ongoing results will be submitted to QAPI. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 3/30/23, from 9:00 a.m. through 3:55 p.m. 51 employees confirmed they had received education on incidents and accidents, reporting incidents via chain of command and to DOH, incident reports, putting interventions in place after incidents/accidents, behavior management, dementia, exit-seeking and wandering, interventions for behaviors and wandering/exit-seeking, elopement protocol including root cause analysis and checking all exits at time of incident, updates on door functioning. Education to include missing person and elopement policy and checklist as updated 2/27/23. The IJ was lifted on 3/30/23, at 4:02 p.m. when the action plan implementation was verified. During an interview on 3/30/23, at 4:02 p.m. the NHA confirmed the facility failed to provide adequate supervision for two residents resulting in elopement (Resident R1 and R2). This failure created an immediate jeopardy situation for 10 of 10 residents residing of the fouth-floor (Residents R1, R2, R4, R5, R6, R7, R8, R9, R10 and R11). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code: 201.29(a)(b)(c)(i)(n) Resident rights. 28 Pa. Code 201.18(b)(1) Management.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on clinical record reviews, observations, and staff interview, it was determined that the facility failed to provide sufficient/competent staff to supervise and promote the safety of residents with mental and psychosocial disorders for two of 52 residents with the diagnoses of Dementia (Resident R1 and R2). Findings include: Review of facility policy Dementia Care dated 1/26/23, indicated it is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well- being. Review of the Admission Record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/12/23, indicated the diagnoses of Alzheimer's Dementia (a group of symptoms that affects memory, thinking and interferes with daily life), Legal Blindness (no vision or sees only light, colors or shapes; eyes do not appear to follow objects), and diabetes (too much sugar in the blood). Section C: Cognitive Patterns, Question C0100 indicated a BIMS score of 3 - severe cognitive impairment. Review of Resident R1's progress notes dated 2/22/23 - 3/18/23 indicated behaviors as follows: 2/22/23 - Resident sitting in hallway talking to himself, states I'm the X-ray technician and I'm here to fix the x-ray machine. 2/23/23 - Resident found on floor in neighboring resident room. 2/24/23 - Physician Employee E1's Progress note references hallucinations (a perception of having seen heard touched, tasted, or smelled something that wasn't actually there) and an increase in falls the past few weeks. 2/27/23 - Haldol (medication to treat mental disorders) ordered to be given at bedtime related to agitation and behaviors; however, did not describe the agitation or behaviors exhibited. 3/16/23 - at 11:54 p.m. Resident restless, ambulating the unit, talking about a dog, escorted to his room by staff who attempted to cover him up with blanket, resident became agitated, stated staff was insubordinate, that he was the boss, and this was his boat. Resident was found on floor ten minutes later. 3/16/23 - at 2:58 p.m. alert with confusion (continued on next page)

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/16/23 - at 9:54 p.m. alert with confusion 3/18/23 - 1:28 p.m. Late entry: resident noted to be in the basement. Staff member from 3rd floor assisted resident to transfer back to the 4th floor where his room is located. During an interview on 3/28/23, at 2:00 p.m. NA Employee E2 indicated somebody approached me on my way back from break in the basement coming to the elevator and said I think he's (Resident R1) lost. NA Employee E2 indicated she knew who he was and took him to the fourth floor. He can see some, I guided him. When I put him on the elevator in the basement the wander guard activated. I have no idea how he got down there. During an interview on 3/29/23, 2:15 p.m. RN Employee E11 indicated not enough staff and they're trying to run a secured unit without a locked unit on the fourth floor. They have real lock down residents who wander up there. It's a lot up there. Some days there's only one nurse for the floor. Third or fourth floor staffing is really bad sometimes. Days and evening sometimes. I was alone this past Saturday for night shift. During an interview on 3/29/23, at 3:30 p.m. NA Employee E22 stated Resident R1 stated Fire engine number nine, fire engine number nine, fire engine number nine. Don't you see those people, NA Employee E22 said what people? Resident R1 said look, and he was telling me to look out the window. I walked up thinking I could nip this in the bud. I said, I don't see anybody. Resident R1 put his hand on her back and she started backing away from him. NA Employee E22 stated Resident R1, I don't see anyone. (He said) look at all those people, they going to get burned, it's a fire. NA stated she again told Resident R1 there was no fire, there was no one there. This was reiterated multiple times. She stated she went back to the curtain, thinking that he was going to be ok. Resident R1 began stated, We gotta get out of here, we gotta get out of here. NA saw him with the electrical object in his hand, swinging it towards the window. NA Employee E22 stated she went down the hall to get other staff. I went down the hall and turned the corner. NA Employee E22 stated that she observed Resident R1 elbow and punch a nurse. NA Employee E22 stated, I was afraid, I'm not trained to stop this and that from going on. I've never worked with mental patients. Employee E22 stated that she has not been provided specific training on dementia, and had no training for violent residents. Review of the admission record indicated Resident R2 admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated the diagnoses Alzheimer's Dementia with severe agitation, paranoid schizophrenia (delusions and hallucinations that blur the line between what is real and what isn't), and atrial fibrillation (irregular heart rhythm). Section C: Cognitive Patterns, Question C0100 indicated a BIMS score of zero - severe cognitive impairment. Review of Resident R2's progress notes dated 3/12/23 - 3/26/23 indicated behaviors as follows: 3/12/23 - refusal of medication 3/13/23 - Physician Employee E1 progress note worsening dementia and wandering 3/16/23 - minimal responses today with some paranoia (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/17/23 - get out of bed independently to bathroom frequently upsetting roommate by closing the door. 3/23/23 - alert with confusion 3/26/23 - NA Employee E12 brought Resident R2 to the 4th floor unit at 3:40 p.m. She was found on the 3rd floor at stairwell. Resident R1 stated she wanted to go to the first floor Villa. Re-directed to room, re-oriented to room and 15 check initiated. Family, Supervisor, and MD notified. Review of written statement from NA Employee E4 dated 3/26/23, indicated at approximately 3:30 p.m. or 3:40 p.m. I was the only aide on the floor and was writing out a work order at the time I saw Resident R2 walk towards her room and round the bend. He did not hear an alarm or anything that would alert him Resident R2 went through the stairwell and he did 15 minute checks afterwards. During an interview on 3/30/22, at 4:02 p.m. the Nursing Home Administrator confirmed that the facility failed to provide sufficient/competent staff to supervise and promote the safety of residents with mental and psychosocial disorders for two of 52 residents with the diagnoses of Dementia (Resident R1 and R2). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code: 201.29(a)(b)(c)(i)(n) Resident rights. 28 Pa. Code 201.18(b)(1) Management.

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety 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** 46336 Based on clinical record and facility document review and staff interview, it was determined that the facility failed to provide the necessary services and failed to make certain appropriate treatment, and services for dementia were provided to ensure safety for one of 44 residents. This failure created an immediate jeopardy situation for one of 44 residents (Resident R1). Findings include: Review of the facility policy, Dementia Care dated 1/26/23, indicated the facility will provide 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. This policy further stated that the care plan interventions will be related to each resident's symptomology. A review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2019, 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 intact 8-12: moderately impaired 0-7: severe impairment Review of Minimum Data Set (MDS, periodic review of resident needs) dated 2/12/23, revealed that Resident R1 was admitted to the facility on [DATE], resident has the current diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), non-traumatic brain injury, and unsteadiness on his feet. Question C0500 BIMS Summary Score revealed Resident R1's score to be 3, severe impairment. Review of Resident R1's February and March physician orders included: -Quetiapine fumarate (Seroquel, an anti-psychotic medication) 12.5 mg, twice daily for psychosis with hallucinations, dated 11/11/22. -Haloperidol (Haldol, an anti-psychotic medication) 0.5 mg sublingually at bedtime for agitation/ behaviors, dated 2/28/23. -Haloperidol 0.5 mg every one-hour as needed for nausea, vomiting, and agitation dated 12/19/22. -Sertraline (Zoloft, an anti-depressant medication) 25 mg daily for depression, dated 11/4/22. Review of Resident R1's medication administration record for February and March 2023, revealed that Resident R1 has needed Haldol on 2/25/23, and 3/7/23. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident R1's plan of care for alteration in cognition dated 9/6/22, did not include interventions for behaviors related to dementia, delusional thoughts, or audio and visual hallucinations. Review of Resident R1's plan of care for have potential for adverse reactions from ongoing use of psychotropic meds. Diagnosis of major depressive disorder dated 9/6/22, included to: -Provide medication as ordered, Seroquel and Zoloft -Monitor for and document behaviors. Notify MD (Doctor of Medicine) as needed for further interventions. -Psych consult as indicated. Review of Resident R1's behavior tracking from 1/1/23, though 3/18/23, included one instance of entering someone else's room, and five instances of refusals of care. Review of Resident R1's progress notes indicated the following: 8/31/22: Entering other rooms. 9/18/22: Delusion that family member having surgery. 10/19/22: Provider note indicted current hallucinations during evaluation. 10/20/22: Delusion he was in the Army and needed to go to work. 11/6/22: Delusional statements, I am not going anywhere with you. I am getting out of here. I am not listening to Hitler or any of them. 11/10/22: Resident looking for a lady and my dog. 12/19/22: Slamming doors, hitting and spitting on staff members, throwing medication, there, now get the hell out of here. 1/1/23: Threw drinks and attempted to strike staff. 2/4/23: Barricaded himself in his room. They are coming to kill me. Oh, you know who, and you two are in on it. Resident R1 walked down the hall, stopped and said, look at those kids over there standing in line. They are waiting to be hung. 3/16/23: (Resident R1) became somewhat restless, ambulating unit, talking about his dog, and wanting ice cream, this LPN (licensed practical nurse) offered him a popsicle, he said no that he likes ice cream. I walked him to his room. He sat on bed, and I attempted to cover him up when he got agitated. He stated that I was insubordinate, and he was the boss, that I was on his boat. I explained to him that he was in (facility). He decided he was going to sit up. Approximately 10 minutes later his roommate was yelling out. Staff goes in, and resident was on the floor. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a late entry progress note dated 3/18/23, at 1:28 p.m. (created 3/24/23, at 3:29 p.m.), indicated resident was noted to be in the basement. Staff member from 3rd floor assisted resident to transfer to the 4th floor. Zero injuries noted visually. Review of facility provided information dated 3/23/23, revealed that on 3/18/23, Resident R1 eloped to an unsupervised area, and that Resident R1 did not recall where he resided. Review of a progress note dated 3/18/23, at 6:15 p.m. indicated staff calling out from room that resident was breaking glass in his window in his room. This nurse entered room and Resident R1 was pounding his recorder into window and glass breaking. I was afraid he would either go out window on 4th floor or cut self on pointed edges of broken glass still hanging in window and tried to pull him away from window as he was hollering out for his son. He became belligerent and combative and elbowed me in my face and scratched down my arm and continued to break the glass and yell out the window. Review of a progress note dated 3/18/23, at 6:28 p.m. indicated: RN (Registered Nurse) was notified of Resident R1 becoming combative. Upon entering the room, the Resident R1 was in the room yelling that the building was on fire and he needed to get out. Staff reports that the resident had become agitated and removed the fire extinguisher from the case and pulled the pin and proceeded to spray the area in an attempt to extinguish a fire. It was then that Resident R1 went into his room and used a piece of medical equipment to break the window and attempting to exit the building through the broken window. A nurse and three nurse aides were present keeping the resident from going towards the broken window and Resident R1 was elbowing and swinging at the staff. Local police had been called prior to RN arriving in the room. Local police arrived on scene. They assisted in getting the patient out of the room safely and assured him that the building was not on fire. Emergency Medical Service was called and Resident R1 was transported to the Emergency Department for psychiatric evaluation. Review of an employee statement written by NA Employee E22 dated 3/20/23, at 10:37 a.m. indicated I could hear Resident R1 yelling fire engine number 9 repeatedly. I stepped round the curtain and he was standing close to the window. I said, what's wrong (Resident R1)? When he said look at that fire, Don't you see all those people? I approached the window to look. Resident R1 then placed his hand on my back, pushing me towards the window. I stepped back and said I don't see anyone, and there is no fire. I tried to reassure him that everything was OK. He then picked up an object, which was attached to an electrical cord and started swinging it at the window. I became afraid and ran screaming for help. Two nurse aides and a nurse came rushing into the room with me. It was too late. Resident R1 was standing at the window holding the object in both hands breaking the window. When the nurse approached him to stop him, he smacked her in the face and elbowed her in the face as well. The other two aides finally got him to stop and sat him down. He was then taken out of the room in a chair. We then began to move the other patient to another room. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of employee statement written by Licensed Practical Nurse (LPN) Employee E23, dated 3/20/23, at 11:07 a.m. indicated: on Saturday I hear someone yelling for help. Please someone help me with this resident. I walked back into the activities room, and the room was smoky. Activities Aide Employee E24 said that Resident R1 had pulled the pin to the fire extinguisher. Resident R1 was in the room holding a wooden welcome sign, and tried to hit me with it as I approached him. I was able to get the sign off him and told him come. Let's go to your room. Resident R1 followed me to his room. I told him it was OK; to sit down and relax. He stood at the foot of the bed for a second looking out the window. He began to say look at all the people. I explained to him that nobody was out there. He sat down on the bed with the walker in front of him and seemed to be calm talking with his roommate. I stayed in his room for a minute. He was calm. I left him sitting on his bed. Review of an employee statement written by Activities Assistant Employee E24 dated 3/20/23, at 11:44 a.m. indicated on Saturday, March 18th, in the evening, Resident R1 was outside the activity room tapping on the window aggressively with a wooden sign that was used for decoration by the door. When I opened the door, there was a cloud of something in the air, and he frantically stated we needed to leave. He entered the activity room, and I noticed his hand was bleeding. I yelled for help. RN Employee E23 ran over with me and noticed the cloud in the air too which was the powder from the fire extinguisher. She looked at his hand that was bleeding and told him to come with her so she could help him. We tried to redirect him out of the activity room. He was not hearing her or seeing her. He was in the room. He broke a file tray. RN Employee E23 successfully got him to leave with her. As I entered the room NA Employee E9 asked me to take a phone call. I had just ended the call when a family member approached (NA Employee E9) and asked if it was normal for glass to come from our rooftop. RN Employee E25 and RN Employee E20 were there as well. And the three of us ran up to 4th floor to see where the glass was coming from. We saw several staff in Resident R1's room cleaning up glass. I saw the situation was under control and left the room at this time. Review of hospital paperwork dated 3/20/23, indicated Resident R1 had been admitted to the hospital for hallucinations and dementia. While in the hospital, Resident R1 had received a TDAP (tetanus/diphtheria/acellular Pertussis) booster vaccine. The hospital history indicated the chief complaint to be increased aggression, with information provided by family that Resident R1 had been having more frequent episodes of hallucinations that have been worsening over the past few weeks. He has a history of longstanding dementia. He is currently on hospice. He was hallucinating the building was on fire. He became more agitated and swung a metal object at a glass window and then cut himself on the hand. He has a small abrasion there. During an interview on 3/29/23, at 12:35 p.m. the Nursing Home Administrator (NHA) confirmed that the facility had not provided education on dementia training to its staff. The NHA further confirmed that Resident R1 had not previously attempted to elope from the facility, and that this was not recognized as a possible change in condition and confirmed that the approaches staff utilized with Resident R1 were not appropriate (refuting the hallucinations while the resident was in crisis, leaving the resident unsupervised and alone with his roommate after aggressive behaviors, not providing additional interventions related to hallucinations, and not providing ordered as needed medications). (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview on 3/29/23, at 3:30 p.m. NA Employee E22 stated Resident R1 stated Fire engine number nine, fire engine number nine, fire engine number nine. Don't you see those people, NA Employee E22 said what people? Resident R1 said look, and he was telling me to look out the window. I walked up thinking I could nip this in the bud. I said, I don't see anybody. Resident R1 put his hand on her back and she started backing away from him. NA Employee E22 stated Resident R1, I don't see anyone. (He said) look at all those people, they're going to get burned. It's a fire. NA stated she again told Resident R1 there was no fire, there was no one there. This was reiterated multiple times. She stated she went back to the curtain, thinking that he was going to be ok. Resident R1 stated, We gotta get out of here, we gotta get out of here. NA saw him with the electrical object in his hand, swinging it towards the window. NA Employee E22 stated she went down the hall to get other staff. I went down the hall and turned the corner. NA Employee E22 stated that she observed Resident R1 elbow and punch a nurse. NA Employee E22 stated, I was afraid, I'm not trained to stop this and that from going on. I've never worked with mental patients. NA Employee E22 stated that she has not been provided specific training on dementia and had no training for violent residents. On 3/29/23, at 2:50 p.m. the NHA was made aware that Immediate Jeopardy (IJ) existed for one of 44 residents in the facility. The IJ template was provided to facility administration, and a corrective action plan was requested. On 3/29/23, at 5:45 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action: Cited resident from incident dated 3/18/23, is no longer in the facility. Resident was ordered routine Haldol, which had been administered per order at bedtime. During the incident, the nurse attempted to utilize non-pharmacological interventions which was effective [sic]. Following the incident, the nurse was educated on interventions including the use of as needed medications. Residents: Whole house audit completed for residents with a diagnosis of dementia to ensure appropriate behavior, tracking by NHA with nurse management team. System Correction: Whole house education for all departments, including nursing, maintenance, therapy, housekeeping, laundry, dietary, administrative, social services, and activities from skilled nursing facility, including agency and hospice staff was conducted regarding advanced and specialty care environments, specific behavioral symptoms and interventions (behavior examples include: agitation, anxious behaviors, depression, insomnia, wandering, delusions, hallucinations, etc.) Support for residents with dementia, types of dementia, and positive approaches for residents with dementia. Dementia education was added to in-person meetings conducted by regional registered nurse on 3/29/23, and mailings/emailing by NHA with completion on 3/29/23. Monitoring: Audits will be completed by the NHA three time per week for four weeks, then weekly for three months for residents with dementia to ensure appropriate care plan and behavior monitoring is in place. Results will be submitted to QAPI (Quality Assurance and Performance Improvement). During interviews on 3/30/23, from 9:00 a.m. through 3:55 p.m. 51 employees confirmed they had received education on types of dementia, dementia symptoms and interventions, and positive approaches for dementia. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was lifted on 3/30/23, at 4:02 p.m. when the action plan implementation was verified. During an interview on 3/30/23, at 4:02 p.m. the NHA confirmed that the facility failed to provide the necessary services and failed to make certain appropriate treatment, and services for dementia were provided to ensure safety for one of 44 residents. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code: 201.29(a)(b)(c)(i)(n) Resident rights. 28 Pa. Code 201.18(b)(1) Management.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on staff interviews and a review of the facility's assessment and resident census and condition it was determined that the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. Findings include: Review of the Facility assessment dated [DATE], indicated the following: Scope: This assessment addresses the following elements: The facility's resident population, including but not limited to: The number of residents and the facility's resident capacity The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population The staff competencies that are necessary to provide the level and types of care needed for the resident population. Diseases/Conditions & Physical/Cognitive Disabilities for Which We Provide Care: Psychiatric/Mood disorders - Psychosis (Hallucinations, Delusions, etc.) Impaired Cognition, and Behavior that Needs Interventions Neurological System -Alzheimer's Disease, Non-Alzheimer's Dementia and traumatic brain injuries. Training Program Evaluation Dementia management and abuse prevention. Caring for residents who are cognitively impaired. Behavior management residents and family. Interview on 3/30/23, at 11:00 a.m. the Nursing Home Administrator confirmed the facility failed to implement its Facility Assessment as described above to care for its specific resident population.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on observation and staff interview, it was determined the facility failed to maintain an environment that was safe and sanitary for residents in two of two nursing units (Third and Fourth Floor nursing units). The findings include: Review of the Environmental Protection Agency (EPA - a federal agency, that sets and enforces rules and standards that protect the environment) publication, Label Review Manual: Chapter Seven, dated 07/2014, indicated the following: - Toxicity Category One: Fatal if swallowed. - Toxicity Category Two: May be fatal if swallowed. - Toxicity Category Three: Harmful if swallowed. Review of the Safety Data Sheet (SDS) for Avistat-D Ready-To-Use Spray Disinfectant Cleaner dated 1/17/21, indicated in Section 2: Hazards Identification that Avistat-D can cause serious eye damage and/or irritation. Review of the SDS for Clorox Clean-Up Cleaner with Bleach dated 12/20/22, indicated in Section 2: Hazards Identification that Clorox Clean-Up Cleaner with Bleach can cause serious eye damage and/or irritation. Review of the SDS for CloroxPro 4 in One Disinfectant and Sanitizer dated 5/13/20, indicated in Section 2: Hazards Identification that CloroxPro 4 in One Disinfectant and Sanitizer is a Toxicity Category Two, and may explode if heated. During an observation of the Fourth Floor Soiled Utility Room on 3/30/23, at 10:20 a.m. the following was noted: -The door to the soiled utility room was unlocked, allowing resident access. -The hopper has soiled water standing at the bottom. -Under sink cabinets not secured. -Soiled towels under the sink. -Spray bottle with an Avistat-D label on it under the sink. -Sink blocked by an office chair with the back cushion removed, leaving the metal post exposed. (continued on next page)

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	03/30/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hand-written sign above the sink that stated Do Not Use Sink. Hand Sanitizer in Soap Dispenser. [NAME] The phrase Hand Sanitizer in Soap Dispenser was lined through. -No soap or sanitizer in the dispenser. -Three needle-disposal containers on the counters. During an observation of the Third Floor Soiled Utility Room on 3/30/23, at 10:45 a.m. the following was noted: -The door to the soiled utility room was unlocked, allowing resident access. -The hopper has soiled water standing at the bottom. -Under sink cabinets not secured. -Three large glass vases under the sink. -Spray bottle with an Clorox Bleach Cleaner label on it under the sink. -Aerosol CloroxPro 4 in One Disinfectant and Sanitizer under the sink. -Two empty buckets under the sink. During an interview on 3/30/23, at 11:15 a.m. the Nursing Home Administrator confirmed the facility failed to maintain an environment that was safe and sanitary for residents on two of two nursing units 28 Pa. Code: 207.2(a) Administrator's responsibility

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	03/30/2023

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 39311 Based on facility education records and staff interview, it was determined the facility failed to ensure education on dementia was provided to staff. The findings include: Review of the Facility Assessment updated 2/21/23, under the Diseases/ Conditions for Which We Provide Care indicated that the facility will provide care for residents diagnosed with neurological system disorders such as Alzheimer's disease, Lewy-body dementia, and non-Alzheimer's dementia. Under the Training Program Evaluation of this assessment indicated that the facility will develop a training plan based on staff needs and resident characteristics, and included dementia management and abuse prevention. During an interview on 3/29/23, at 10:15 a.m. the Nursing Home Administrator (NHA) was asked to provide education records for facility staff for the previous two years. During an interview on 3/29/23, at 10:45 a.m. the NHA provided education records and sign-in sheets. Review of these records failed to reveal dementia training records. During an interview on 3/29/23, at 12:35 p.m. the NHA confirmed that the facility had not provided education on dementia training to its staff. During an interview on 3/30/23, at 4:02 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure education on dementia was provided to staff.