STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305024	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Manor	40 Whitehall 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, it was determined that the facility failed to thoroughly investigate after a resident's fall for 1 of 1 resident reviewed for falls in a final sample of 18 residents. (Resident Identifier is #82). Findings include: Review on 6/6/25 of the facility's policy titled Abuse Prohibition revised on 10/24/22 revealed, .The Center will implement an abuse prohibition program through the following: .Investigation of incidents and allegations; . Reporting of incidents, investigations, and Center response to the results of their investigations .10. At monthly Quality Assurance and Performance Improvement (QAPI) meetings, review all allegations of abuse, neglect, misappropriation of patient property, and exploitation that were reported to the state to: 10.1 Analyze occurrences to determine what changes are needed, if any, to prevent further occurrences; 10.2 Identify situations which a potential for risk; and 10.3 Determine what preventative measures will be implemented by staff. Review on 6/6/25 of Resident #82's Progress Note dated 4/24/25 at 5:22 p.m. and signed by Staff C (Registered Nurse) revealed, Pt's [Patient's] roommate came out in hall looking for a nurse, saying that pt had fallen, Nurse responded immediately, abd [abdomen] pt was found on the ground laying on [pronoun omitted] left side. Pt was unresponsive and not able to follow cues. 911 was immediately notified. Pt was observed to have twitches, and a pillow was applied to under [pronoun was omitted] head. Pt was asked to wait on the floor. 911 was notified. Daughter updated, PA [Physician Assistant] updated, Report called into [Hospital name omitted]. Pt was unable to respond appropriately to questions, Breathing WNL [Within Normal Limits]. Pt. sent with BIPAP [Bilevel Positive Airway Pressure] machine and Daughter called back and was updated on pt's situation. Pt. transferred to [Pronoun omitted] by EMTs [Emergency Medical Technician] at 5:00 p.m. on 4/24/25. Interview on 6/6/25 at 11:00 a.m. with Staff C confirmed the above and revealed that Resident #82 was unresponsive to answering questions. Staff C found Resident #82 by his/her bed so assumed he/she fell out of bed, but is not sure, since the resident was unable to answer any questions. Staff C assessed Resident#82 where he/she had fallen and did not move the Resident #82, but EMS providers arrive within 5 minutes of calling them. Further interview with Staff C on 6/6/25 at approximately 11:00 a.m. revealed that he/she fill in the required incident report and EMS paperwork, but no other paperwork was asked for regarding the fall for an investigation. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/6/25 at approximately 10:30 a.m. with Staff B (Director of Nursing) and Staff D (Administrator), revealed that the facility did not attempt to further investigate into the fall to see what the circumstances were. Staff B and Staff D confirmed that neither one had interviewed the roommate or staff after the fall. Staff B and Staff C confirmed the facility had no evidence the facility had interview or investigated the fall. Review on 6/6/25 of the facility's policy titled Falls Management revised on 3/15/24 revealed, . A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., patient pushes another patient 5. Post-Fall Management: . 5.5 Document circumstances of the fall, post -fall assessment , and patient outcome;