STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335439	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pearl Nursing Center of Rochester	1335 Portland Avenue Rochester, NY 14621

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interviews, and record review conducted during an Abbreviated Survey (ACTS Reference Number: NY00370341, Intake ID: Complaint 571451) from 09/08/2025 to 09/10/2025, the facility did not ensure a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for one (1) (Resident #9) of three (3) residents reviewed. Specifically, Resident #9 was identified to be at risk for pressure ulcers, did not have care planned interventions in place to prevent skin breakdown, and later developed a pressure ulcer. Additionally, there was no documented evidence interventions to promote healing of the new pressure ulcer were implemented until three (3) days after the wound was first identified. This is evidenced by the following:The undated facility policy Pressure Ulcers/Skin Breakdown - Clinical Protocol included nursing staff and practitioners will assess and document each resident's risk factors for developing pressure sores such as immobility, recent weight loss, and a history of pressure ulcer(s). The physician will order pertinent wound treatments and help identify medical intervention for wound management. Resident #9 had diagnoses including a stage two (2) (a partial-thickness skin injury) pressure ulcer of the sacral region (bony area at the top of the buttocks), history of stroke with right-side paralysis, and severe malnutrition. The Minimum Data Set (a resident assessment tool), dated 10/08/2024, documented Resident #9's cognitive function was undetermined, they were incontinent of bowel and bladder, dependent on staff for toileting, bed mobility, and transfer assistance, were at risk for pressure ulcers, and had no unhealed pressure ulcers. The comprehensive care plan, dated 11/06/2024, identified the resident had a self-care deficit and limited physical mobility. Interventions included, but were not limited to, dependent on staff for transfers, toileting, eating, bathing, and personal hygiene. The care plan did not include measurable goals and/or interventions related to Resident #9's risk of developing pressure ulcers. Review of the current Kardex (care plan used by certified nursing assistants to direct daily care) included Resident #9 was dependent on staff for transfers, toileting, eating, bathing, and personal hygiene. The care plan did not address the resident's pressure ulcer risk or include interventions to assist with preventing skin breakdown. Progress notes reviewed from 11/01/2024 to 11/22/2024 revealed a nursing note, dated 11/19/2024, documenting Resident #9 had a reddened area on their bottom and a note was put in the medical provider book (used by nursing staff to communicate changes in a resident's condition to the medical team). In a wound care provider note, dated 11/20/2024, Physician #1 documented Resident #9 was seen for a wound assessment including a new deep tissue injury (a localized area of tissue damage that develops due to prolonged pressure on the skin) to their sacrum, measuring 3.0 centimeters in length, 5.0 centimeters in width, and no measurable depth. The surrounding skin had maceration (softening and weakening of the skin due to prolonged exposure to moisture) and erythema (redness). Treatment recommendations included to cleanse the wound with mild soap and water, apply a thick layer of TRIAD cream (wound treatment used to promote healing) to the wound and surrounding skin, and leave open to air every shift and as needed. Additional recommendations included, but were not limited to, offloading (reducing pressure on the affected area to promote healing), use of the facility pressure injury prevention protocol, a pressure redistribution cushion per facility protocol, and applying barrier cream three (3) times daily and after incontinence episodes. Review of Resident #9's Order Summary Report (medical orders) revealed a treatment order for the sacral wound dated 11/22/2024. There was no documented evidence preventative measures or treatment orders for the sacrum had been ordered prior to 11/22/2024. During an interview on 09/09/2025 at 1:52 PM, Certified Nursing Assistant #1 stated they would know if a resident was at risk for developing pressure ulcers and required skin prevention interventions by looking at the resident's Kardex. During an interview on 09/10/2025 at 9:27 AM, Licensed Practical Nurse #1, stated all residents at risk for skin breakdown should be repositioned every two (2) hours and if they identified new skin breakdown they would document it in the medical provider book. During an interview on 09/10/2025 at 9:14 AM, Registered Nurse #1 stated skin breakdown prevention interventions for residents would include to turn and reposition, encourage them to get out of bed, provide timely incontinence care, and promote good nutrition. They stated they would find instructions for turning and repositioning in the resident's medical orders. During an interview on 09/09/2025 at 9:38 AM, Licensed Practical Nurse Manager #1 stated if a resident had a new skin concern, they would have a registered nurse assess the resident and follow the facility's general wound care process or verbal orders until the resident was seen by the wound care provider on their weekly skin rounds

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews conducted during an Abbreviated Survey (ACTS Reference Number: NY00370341, Intake ID: Complaint 571451) from 09/08/2025 to 09/10/2025, the facility did not ensure each resident received and the facility provided food and drink that was palatable and at a safe and appetizing temperature for one (1) of one (1) test tray. Specifically, food and beverages during the lunch meal on 09/09/2025 were served at sub-optimal temperatures. This is evidenced by the following:During a tray line and lunch time observation on 09/09/2025, the tray delivery cart was loaded in the main kitchen and sent to Residential Unit 1 at 12:13 PM. The final meal tray was passed to a resident on the unit at 12:39 PM and test tray temperatures were taken at that time by a New York State Department of Health Surveyor, with the Food Services Director present, using the surveyor's calibrated thermometer. The findings included:Roasted potatoes: 101.3 degrees FahrenheitHoney ham: 110.6 degrees FahrenheitCooked asparagus: 101.8 degrees FahrenheitBlack coffee: 127.3 degrees Fahrenheit During an interview on 09/09/2025 at 12:44 PM, the Food Services Director stated they did not know the food would cool down that much between setting up the trays in the kitchen and passing them to residents on the units. They stated the food was cold and it was not okay. During an interview on 09/09/2025 at 1:17 PM, Resident #12 stated food that should be hot is sometimes served cold. 10 NYCRR 415.14(d)(1) Subpart 14-1.40(a)