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	06/28/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26883 Based on observations and interviews conducted during the Recertification Survey, for three (first, second, and third floors) of three resident-use floors and one of one basement, the facility did not provide housekeeping or maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically: exhaust ventilation was not functional, plumbing fixtures were not maintained and/or working properly, hot water temperatures were not maintained between 90 and 120 degrees Fahrenheit (F), lighting was not functional, light lenses and covers were missing, there were cracked and damaged tiles, doors and walls were damaged, a resident room lacked a means for securing valuables, there were resident care items stored on the floor, and there was an accumulation of bugs in stairwells. The findings are: Observations during the initial tour of the facility on 6/24/24 from 8:50 AM to 1:30 PM included the following: a) The exhaust ventilation in the following areas were observed to not be drawing air out of the rooms: in the ceiling of the bathroom in room [ROOM NUMBER], the shower room across from the 2nd floor staff bathroom, the first-floor soiled utility room, the janitor's closet next to room [ROOM NUMBER], and the shared bathroom for rooms [ROOM NUMBERS]. b) The light lenses in the corridor outside room [ROOM NUMBER] (3rd floor), in the 3rd floor soiled utility room, and in the shower room were cracked and broken. c) The hand wash sink in the 3rd floor shower room only discharged a small trickle of water and would not shut off using the valve handles. d) The floor tiles near the sink in room [ROOM NUMBER] were cracked with small sections missing. e) The janitor's closet next to room [ROOM NUMBER] contained a floor sink and the room did not have functional exhaust. f) There were multiple missing ceiling tiles in the shower room near room [ROOM NUMBER] (first floor). g) The hopper (flushing rim fixture) in the first-floor soiled utility room was clogged with a brown liquid and a sign nearby read: do not flush. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h) There were resident care supplies including a brush, shampoo, ointment, and bed pans stored on the floor inside the first-floor supply closet next to room [ROOM NUMBER]. Additionally, a shelf in this room was tipped and coming off of the wall. Observations on 6/25/24 at 8:40 AM included a mechanical exhaust fan attached to duct work located near the ceiling above the washing machines in the basement laundry room that was not functional and heavily coated with dust. Further observations included a large open circular duct above the dryers that was improperly vented across the hallway into the generator room. During an interview at this time, the Director of Maintenance stated that a vendor was contacted to evaluate/troubleshoot the issue but would not come out to the facility because they are owed money. Observations on 6/25/24 at 8:45 AM included no hand washing sink in the basement laundry room. Observations on 6/25/24 at 9:00 AM included the plate warmer (lowerator) in the main kitchen had a frayed cord with exposed wires near the plug. During an interview at this time, the Dietary Manager stated that they had put in a maintenance order to get it fixed but the new maintenance director just started yesterday. Observations on 6/25/24 from 9:39 AM to 9:55 AM included the tops and bottoms of the emergency exit stairwells of the north and south stairwells had a large accumulation of dead bugs and spiderwebs. Further observations included the doors at the tops of each stairwell were open approximately 1/2- to 1-inch. During an interview at this time, the Director of Maintenance stated that they were told that there were no keys for the roof doors. Observations on 6/25/24 at 11:00 AM included the refrigerator in the 2nd floor dining room had a sign posted on the door that it was broken. When interviewed, the 2nd floor Licensed Practical Nurse Manager stated that it broke last Friday and they did send a work order to Maintenance but does not know if they have started working on it. Observations on 6/25/24 at 10:28 AM included the sink drainpipe was disconnected in resident room [ROOM NUMBER] and there was a sign on the sink that read: Do not use broken sink. Observations on 6/26/24 at 11:15 AM included the sink faucet in resident room [ROOM NUMBER] was very loose and water could not be shut off using the valve handles. Further observations included the cabinet near the window bed had a lockable drawer that was open and unlocked. During an interview at this time, Resident #34 stated someone had been stealing and they did not have nor were they offered a key to the cabinet drawer. Observations on 6/27/24 at 9:13 AM included pooling water on the floor in the basement boiler room from a leaking pipe above the boilers. 10 NYCRR: 415.29, 415.29(c), 415.29(d), 415.29(g), 415.29(h)(1), 415.29(i)(1,2), 415.29(j)(1)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 46880 Based on interviews and record review conducted during the Recertification Survey for eight (Residents #9, 22, 32, 36, 70, 78, 102, and 112) of eight residents reviewed for Baseline Care Plans, the facility did not ensure that a Baseline Care Plan summary was provided to the residents and/or resident representatives. Specifically, the facility was unable to provide evidence that a written summary of their Baseline Care Plan (developed within 48 hours of admission and included minimum healthcare information necessary to properly care for the immediate needs of the residents and that they were able to understand) had been provided to any of the residents and/or their representatives. This is evidenced by, but not limited to the following: The facility's policy, Care Plans - Baseline revised in March 2022, documented: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The resident and/or representative are provided a written summary of the Baseline Care Plan in a language that the resident/representative can understand. Resident #9 had diagnoses that included diabetes, chronic kidney disease, and schizoaffective disorder (a mental health condition). The Minimum Data Set Resident assessment dated [DATE], documented the resident was moderately impaired cognitively, and that it was very important to them to have their family involved in discussions pertaining to their care. Resident #70 had diagnoses that included dysphagia (difficulty swallowing), pneumonitis (inflammation of lung tissue), and diabetes. The Minimum Data Set Resident assessment dated [DATE], documented the resident was moderately impaired cognitively and able to understand others with clear comprehension. Resident #78 had diagnoses including diabetes, osteoarthritis of both hips (a degenerative joint disease), and a stage four (full thickness tissue loss) pressure ulcer of the sacral (the bottom of the spine) region. The Minimum Data Set Resident assessment dated [DATE], documented the resident was cognitively intact. Review of Baseline Care Plans for Residents #9, 70, and 78 revealed that a written summary had been developed following admission to the facility, but there was no evidence that a copy of it had been provided to any of the residents or their representatives. The area on the Baseline Care Plan designated for the resident's and/or their representative's confirmation that the summary had been reviewed and/or provided was blank for all residents reviewed. During an interview on 6/27/24 at 9:23 AM, the Director of Social Work said their process included that the resident and/or their representative would sign the Baseline Care Plan summary (after review) then they would print it and give them a copy of it. The Director of Social Work said they were only recently made aware that the Baseline Care Plans were part of the Social Worker's responsibility. (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 6/28/24 at 10:09 AM, the Acting Director of Nursing said that Baseline Care Plans were the Social Worker's responsibility and that the resident and/or their representative should receive a copy of it. The Acting Director of Nursing said they had trained the Director of Social Work to enter a progress note showing they had provided a copy of the Baseline Care Plan to the resident and/or their representative and especially for the families who could not come into the facility. The Acting Director of Nursing said they were aware that the system was broken and needed fixing. 10 NYCRR 415.11

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46880 Based on interviews and record review conducted during the Recertification Survey, the facility did not ensure that services were provided and/or arranged for the accepted standards of quality that should have been provided for two (Residents #9 and #70) of five residents reviewed. Specifically, lab services were not provided as recommended by pharmacy and ordered by the Physician. This is evidenced by the following: When requested, the facility was unable to provide any policies related to obtaining lab work or a blood draw protocol. 1. Resident #70 had diagnoses that included dysphagia (difficulty swallowing), pneumonitis (inflammation of lung tissue), and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented the resident was moderately impaired cognitively and did not exhibit behaviors or refusals of care at that time. The current Comprehensive Care Plan revised on 2/16/24 revealed Resident #70 required tube feeding related to dysphagia and could not have foods or fluids by mouth. Nursing interventions included obtaining and monitoring labs and diagnostics as ordered and reporting the results to the medical provider as indicated. Review of Resident #70's Medication Regimen Review dated 3/14/24 revealed that the pharmacist recommended a Basic Metabolic Panel (a blood test that measures the body's chemical balance and metabolism) due to receiving Lasix (a diuretic medication commonly known as a water pill that can cause multiple side effects such as electrolyte imbalances). Physician #1 agreed with the recommendation and signed the Medication Regimen Review on 3/16/24. Review of Resident #70's electronic medical record revealed no evidence that the lab work had been completed as recommended by the Pharmacist and the Physician or that the resident had refused any lab work. 2. Resident #9 had diagnoses that included diabetes, chronic kidney disease, and schizoaffective disorder (form of mental illness). The Minimum Data Set Resident assessment dated [DATE] documented the resident was moderately impaired cognitively and did not exhibit any refusals of care at that time. Review of Physician orders dated 3/8/24 revealed orders for a hemoglobin A1C (blood work used to monitor blood glucose levels) and a lipid panel (blood work used to monitor cholesterol). Review of the Medication Regimen Review for April 2024 revealed the Pharmacist's recommendation for a lipid panel and a hemoglobin A1C due to Resident #9's medication regimen. Physician #1 agreed, signed the Medication Regimen Review on 4/18/24 and again ordered a lipid panel and a hemoglobin A1C . Review of Resident #9's electronic medical records revealed no evidence that the lab work had been completed as ordered by the Physician or that the resident had refused lab work. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 12:16 PM, Registered Nurse Manager #1 said that when the provider (Physician) orders lab work, the nurses are supposed to collect the blood draws in-house on Tuesdays and Thursdays, call the hospital for the labs to be picked up, and within 24 hours the lab results should be available. Registered Nurse Manager #1 said a paper copy of the labs would come through via fax and be reviewed by a nurse and the provider before being scanned into the resident's electronic health record. During an interview on 6/27/24 at 4:40 PM, the Registered Nurse/wound care/infection control nurse stated that the labs for Residents #9 and #70 were not done as ordered and that they reached out to the medical team to see if they still wanted the labs done and they had replied yes. During an interview on 6/28/24 at 9:42 AM, Physician #1 said Resident #9 and #70's labs should have been drawn as ordered unless it was a difficult blood draw or the residents refused. In which case, Physician #1 said there should be a note in the chart, and they should have been notified as to why the labs were not completed. During an interview on 6/28/24 at 10:17 AM, the Acting Director of Nursing said the Director of Nursing was responsible for reviewing the Medication Regimen Reviews, but they had not reviewed any since they had been in their role effective 6/1/24. Additionally, the Acting Director of Nursing said they did not have an answer for why the labs were overlooked, but they would expect the nurses to document any refusals. The Acting Director of Nursing said it had not been brought to their attention that either resident had refused lab work. 10 NYCRR 415.20

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00319773), the facility did not ensure residents received treatment and care in accordance with professional standards of practice for two (Residents #30 and #42) of five residents reviewed. Specifically, the facility could not provide evidence that physician-ordered wound care treatments were provided as ordered. This is evidenced by the following: 1. Resident #30 had diagnoses including chronic ulcers of left leg, chronic obstructive pulmonary disease (COPD-disease of the lungs causing difficulty to breath), and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented that Resident #30 was cognitively intact and had a skin ulcer that required a dressing. Current Physician orders for Resident #30's left leg wounds included to clean the wounds with wound cleanser, apply zinc oxide to the macerated skin, cover it silver alginate (wound treatment often used for infected wounds), apply an absorbative non-bordered dressing, wrap in gauze, secure with tape, and change daily and as needed. The orders also included to wrap the resident's leg with an ace wrap in the mornings and remove it in the evenings. During observations on 6/26/24 at 12:35 PM and 6/27/24 at 1:38 PM, Resident #30 was not wearing any ace wraps to the left leg. In an observation of wound care on 6/26/24 Licensed Practical Nurse #2 completed Resident #30's wound care (silver dollar sized venous ulcer) as ordered. An ace wrap was not applied as ordered following the dressing change. Review of Resident #30's June 2024 Treatment Administration Record revealed documentation that the dressing had been completed on both 6/26/24 and on 6/27/24. Additionally, review of the June 2024 Treatment Administration Record revealed missing documentation (dressing not signed off by nursing as completed for 8 out of 27 opportunities related to the left anterior wound dressing change). During an interview on 6/27/24 at 1:37 PM, Resident #30 stated that they used to have an ace wrap on the wound but that the wound nurse had said a few weeks ago to leave them off and let the wound dry. During an interview on 6/27/24 at 2:00 PM, Licensed Practical Nurse #2 stated the wound order was confusing and that they were not aware that there was a separate order for ace wraps (which was signed off as completed on the Treatment Administration Record). During an interview on 6/28/24 at 11:39 AM, Licensed Practical Nurse Manager #2 stated that the way the order was written, Resident #30's ace wraps should have been written as a second order and not included with the dressing change order. During an interview on 6/28/24 at 12:49 PM, the Acting Director of Nursing stated that nursing should follow the physician's order as written. If the order was confusing or not understood, staff should clarify the order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #42 had diagnoses including diabetes, morbid obesity, and a recent surgical abdominal wound. The Minimum Data Set Resident assessment dated [DATE] documented that Resident #42 was cognitively intact. Physician orders dated 6/7/24 for Resident # 42's abdominal wound included to clean the wound with wound cleanser, apply skin prep (protective skin treatment) around the wound, apply calcium alginate (an absorbent wound treatment) to the wound, cover it with an absorbent dressing, and change it three times a week every Monday, Wednesday, Friday and as needed. On 6/20/24, the Physician changed the abdomen dressing to daily and as needed. Review of Resident #42's Treatment Administration Record from 6/7/24 to 6/27/24 revealed that on 4 of 14 opportunities there was no documentation that the wound care had been provided as ordered. There was no documented evidence that the resident had refused any dressing changes. Review of a wound care note dated 6/19/24 revealed Resident #42's abdominal wound was 7 centimeters by 15 centimeters and on 6/25/25 the wound care note included the wound was improved with a size of 6 centimeters by 14 centimeters. In an interview on 6/28/24 at 9:59 AM, Medical Provider #1 stated orders should be acted on (as ordered). Medical Provider #1 stated that if a resident refused a treatment, nursing staff would notify the medical team. During an interview on 6/28/24 at 12:49 PM, the Acting Director of Nursing stated they would expect nursing staff to carry out (provide) wound treatments as ordered and if unable to complete for any reason, they should contact the medical provider. The Acting Director of Nursing said a blank box on the Medication (or Treatment) Administration Record indicated the medication (or treatment) was not signed off or not given (done). 10 NYCRR 415.12 46526

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 26883 Based on observations, interviews, and record review conducted during the Recertification Survey for one (Resident #42) of six residents reviewed, one of one basement laundry room and nine (Resident Rooms #106, 108, 111, 120, 122, 208, 220, 306, and 307) of nine resident rooms reviewed, the facility did not ensure the environment remained free from accident hazards. Specifically, for Resident #42, who was known to vape in their room, the facility did not ensure the resident was assessed for and care planned for the use of electronic cigarettes in the facility. The basement laundry room had a significant buildup of lint behind dryers creating a fire hazard and multiple resident rooms had water temperatures above 120 degrees Fahrenheit at points of use. This is evidenced by the following: 1. During an observation on 6/24/24 at 1:30 PM, there was significant buildup of lint behind the dryers in the basement laundry room. The lint was approximately one to two-inches thick and covered the top and rear surfaces of two natural gas-powered dryers, the walls, the floors, electrical wires, and motors. Additionally, lint was coming out of an open junction in the exhaust duct work while the dryer was running. During an observation and interview on 6/24/24 at 3:05 PM, there was a smell of smoke and a light haze in the basement corridor outside the laundry room. The Director of Maintenance stated they were cleaning the lint behind the dryers and a spark from the dryer ignited the lint. They immediately used a fire extinguisher to put out the fire and turned off all electricity to the room. 2. During an observation on 6/26/24 at 10:56 AM, the in-line temperature gauge at the mixing valve for outgoing water located in the basement boiler room displayed 132 degrees Fahrenheit. During an observation on 6/26/24 at 11:40 AM, the sink water temperature in resident room [ROOM NUMBER] was 127.9 degrees Fahrenheit. The surveyor's digital thermometer was checked for proper calibration at that time using crushed ice and water and displayed 32.5 degrees Fahrenheit. Review of water temperature logs provided by the facility revealed the following temperatures exceeding 120 degrees Fahrenheit and did not include any documented corrective action: - On 4/23/24, resident room [ROOM NUMBER] was documented as 124 degrees Fahrenheit - On 5/14/24, resident room [ROOM NUMBER] was documented as 130.1 degrees Fahrenheit - On 6/05/24, resident room [ROOM NUMBER] was documented as 125.4 degrees Fahrenheit - On 6/13/24, resident room [ROOM NUMBER] was documented as 122.1 degrees Fahrenheit - On 6/17/24, resident room [ROOM NUMBER] was documented as 125.6 degrees Fahrenheit - On 6/18/24, resident room [ROOM NUMBER] was documented as 123.8 degrees Fahrenheit - On 6/24/24, resident room [ROOM NUMBER] was documented as 125.4 degrees Fahrenheit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 6/25/24, resident room [ROOM NUMBER] was documented as 122.4 degrees Fahrenheit - On 6/26/24, resident room [ROOM NUMBER] was documented as 127.4 degrees Fahrenheit During an interview on 6/28/24 at 2:48 PM with the Regional Director of Operations, the Corporate Infection Control Nurse, and the Regional Director of Clinical Services, the Regional Director of Operations stated they were aware of issues related to the physical environment and were waiting to hear back from a vendor with a quote to evaluate the hot water. Review of the facility policy, Water Temperatures, Safety of, dated May 2024, revealed the policy included: water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas would be set to temperatures of no more than 120 degrees Fahrenheit, maintenance staff were responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log, and if at any time water temperatures felt excessive to touch, staff would report findings to the immediate supervisor. 3. Resident #42 was admitted to the facility approximately two and a half years ago and has diagnoses including, arthropathy (a disease of the joints often causing muscle weakness), and peripheral vascular disease. The Minimum Data Resident assessment dated [DATE] revealed the resident was cognitively intact, dependent on staff for all activities of daily living and under tobacco use, the assessment was blank. Review of the undated facility policy, Tobacco-Free Environment Policy, revealed the facility prohibited the use of tobacco and tobacco products, including but not limited to, electronic cigarettes by residents, employees, and others entering the facility premises. There would be no designated smoking areas on the premises unless specifically identified for the use of residents admitted to the facility before implementation of the policy. For current residents that smoked prior to the policy implementation, residents were allowed to use tobacco or tobacco products in a designated area outside and were required to have a smoking assessment completed to determine the level of supervision to be provided and interventions to mitigate (to reduce the occurrence of a severe outcome) the risk of injury. The employee's responsibilities in enforcing the policy included, but were not limited to, reporting witnessed violations immediately to the Executive Director, Director of Nursing, Nurse Manager, or Nurse Supervisor. Residents would be asked to immediately comply with the facility policy and any tobacco products found would be confiscated and returned upon discharge from the facility. Review of an Admission Agreement, dated 1/4/21 and signed by Resident #42, revealed that smoking was never allowed in any area inside the facility, the facility did allow outdoor smoking for residents within specific smoking times, and if a resident would like to smoke, they would sign and adhere to the rules outlined in the facility smoking policy. Review of the current comprehensive care plan, revealed Resident #42 was non-compliant with the facility smoking/vaping policy and hoards vapes in their room (private) which they refuse to surrender to staff when requested. Interventions included to offer smoking cessation information, to ensure resident was aware of the facility policy, and to document refusals to turnover possession of vaping materials. Review of current physician orders included two (2) liters oxygen via nasal cannula (a device that delivers oxygen through the nose) on at bedtime and off in the morning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note, dated 9/27/23 at 10:04 AM, Social Worker #1 documented the interdisciplinary team met for Resident #42's annual care conference and the resident was present. Nursing addressed that Resident #42 should not be vaping in the facility and the interdisciplinary team would implement weekly meetings to ensure this was not happening. Resident #42 was offered a nicotine patch (used for smoking cessation) but declined. Review of nursing progress notes from 5/4/24 to 5/19/24 revealed frequent documentation regarding either Resident #42 holding a vape pen, smoking a vape pen, or the presence of a vape pen in their room. Progress notes revealed Resident #42 frequently refused to give the vape pen to staff upon their request, and often became agitated and verbally combative and administration staff were notified. The facility was unable to provide any Incident/Accident Reports related to Resident #42's smokeing a vape pen in their room or any assessement done for the safe use of a vape pen in their room. During an observation and interview on 6/24/24 at 10:26 AM, a vape pen was laying on top of Resident #42's bedside table. When asked what it was, Resident #42 stated it was a BIC pen used for writing and asked, are you going to tell on me? During an interview on 6/26/24 at 1:31 PM, Certified Nursing Assistant #2 stated their were a few residents in the facility who smoked and Resident #42 vaped. They had not seen Resident #42 vaping but had seen the vapes on their dresser. During an interview on 6/27/24 at 4:28 PM, Resident #42 stated they did vape in their room and that they had been offered nicotine patches but they made them sick. Resident #42 stated they needed to quit smoking and would try other methods of smoking cessation. During an interview on 6/28/24 at 11:37 AM, Licensed Practical Nurse Manager #2 stated there should be no smoking or vaping at the facility because they were a non-smoking facility. If residents were observed smoking, staff should conduct a search of their room and if materials were found an incident and accident report should be completed. Licensed Practical Nurse Manager #2 stated they had received frequent complaints of Resident #42 vaping in their room and was not sure how the resident kept getting the vapes. The facility had offered Resident #42 smoking cessation products and made transfer referrals to other facilities, but a smoking assessment had never been done because they were a non-smoking facility. Licensed Practical Nurse Manager #2 stated that frequent checks for materials were not done for Resident #42 and checks were only done when staff reported a concern. During an interview on 6/28/24 at 12:49 PM, the Regional Director of Clinical Services stated the facility was non-smoking and residents signed an agreement not to smoke upon admission. Smoking assessments were not done because it was a non-smoking facility. The Regional Director of Clinical Services stated that smoking cessation could be offered, but most residents decline. Resident #42's continued vaping was an issue of non-compliance with their care plan and staff should be keeping a record of the non-compliance. The Regional Director of Clinical Services stated Resident #42 required ongoing monitoring to ensure their safety and that of other residents. (continued on next page)

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	335439	A. Building B. Wing	06/28/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/24 at 2:48 PM with the Regional Director of Operations, the Corporate Infection Control Nurse, and the Regional Director of Clinical Services, the Regional Director of Operations stated they were not aware Resident #42 had been vaping in their room and if found an incident report should be completed, and smoking cessation offered. The Regional Director of Clinical Services stated staff were not consistently documenting or completing incident reports when they became aware of the resident vaping in their room. 10 NYCRR 415.12(h)(1-2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 25744 Based on interviews and record review conducted during the Recertification Survey, for two (1st and 2nd floor units) of three residential care units reviewed, the facility did not ensure that an accurate reconciliation of all controlled substances (narcotic medications) was consistently completed. Specifically, the narcotic count logs which included reconciliation of narcotic medications at the end of each shift were not consistently signed to indicate the count had been done and the correct count of narcotic medications had been verified by two nurses. This was evidenced by the following: The facility policy Medication - Controlled Substances, dated April 2019, included that narcotics would be counted with two professional nurses and documentation that the count was completed and accurate would be completed at the beginning and end of each shift. Any discrepancy in a shift-to-shift count must be immediately communicated to the Director of Nursing. 1. Review of the second-floor south medication cart on 6/27/24 at 10:30 AM revealed that the Controlled Substance Inventory logs dated 4/1/24 to 5/18/24 (the only sheets provided when prior three months requested) had numerous (greater than twenty) missing signatures, including multiple days in a row, to verify that the controlled substance count had been completed and was accurate, and that the shift-to-shift narcotic count had been completed by two nurses. When interviewed at the time, Licensed Practical Nurse #2 said that the narcotic sheets should be signed as a legal document that included how many drugs/pills were received and how many were left. When completed, the sheets should be sent to medical records. The Controlled Substance Inventory logs include the date, time, resident's name, and medication given and total counts were done at the end of each shift. When asked the whereabouts of the inventory log from the prior day, Licensed Practical Nurse #2 stated they were unaware and that the night shift nurses most likely did not sign off for the narcotic count being completed. 2. Review of the first-floor south medication cart on 6/27/24 at 11:05 AM the Controlled Substance Inventory logs for the previous three months contained numerous missing signatures (greater than 30) to verify that the shift-to-shift narcotic count had been completed. When interviewed at this time, Licensed Practical Nurse #4 stated that the yellow sheet comes with the blister packs (of narcotics from pharmacy). We fill out date, time, tablets given, how many we started with and then what was left. The Controlled Substance Inventory log is filled out with each resident's name, date, and time, with medication and prescription number. At the end of the shift a count is done with the nurse coming on and the nurse going off and both should sign as to the accuracy of the count. In addition, both should sign the narcotic sheet for the receiving nurse and the surrendering nurse (of the narcotic keys). Licensed Practical Nurse #4 stated that doing the narcotic count at the end of the shift is done to make sure the correct medication was given and that the count (of medications left) is correct. When interviewed on 6/27/24 at 11:45 AM, Licensed Practical Nurse Manager #2 stated that all nurses know to sign out on the narcotic sheets with the outgoing and incoming staff signatures and to inform a nursing supervisor if there are missing signatures. Licensed Practical Nurse Manager #2 said that the purpose of the count was to keep track of the narcotic (medications) count and who has the narcotic keys and that the narcotic sheets from earlier this week were missing signatures. (continued on next page)

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	335439	A. Building B. Wing	06/28/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.18(b)(1)(2)(3)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641 Based on interviews and record review conducted during the Recertification Survey and complaint investigation (NY00313302), it was determined that for one (Resident #10) of six residents reviewed for medication administration, the facility did not ensure that the residents were free from significant medication errors. Specifically, there was no documented evidence that Resident #10 had received their antipsychotic medication (medications used to treat mental illness) on multiple days. This is evidenced by the following: Resident #10 had diagnosis that included paranoid schizophrenia (a type of mental illness), Crohn's disease (an inflammatory bowel disease), and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented the resident had moderate impairment of cognitive function and no refusals of care or behaviors at that time. Physician orders dated 12/15/23 through 3/22/24 included clozapine 300 milligrams to be given at bedtime for chronic paranoid schizophrenia. Physician orders dated 1/2/24 included blood work for complete blood count, clozapine panel, and absolute neutrophil count for monitoring the use of clozapine. These tests were again ordered on 1/8/24. Review of the Medication Administration Record revealed that on 12/30/23, 12/31/23 and 1/3/24 the clozapine was documented as on hold. On 1/1/24 and 1/4/24 clozapine was documented as refused. On 1/6/24, 1/7/24, and 1/9/24 the Medication Administration Record documented that the clozapine was not administered due to either nausea or that resident was hospitalized . The clozapine was documented as given on 1/2/24, 1/5/24, and 1/8/24 (despite the prescription not being refilled by pharmacy). Review of Resident #10's electronic medical record revealed no evidence that the Physician ordered the medication to be held on 12/30/24, 12/31/24 and 1/3/24, no evidence that the resident refused the medication on 1/6/24, 1/7/24 and 1/9/24, no evidence that the resident had been hospitalized during that time and no evidence that the lab work had been completed following the physician orders on 1/2/24. In a nursing progress note dated 1/7/24, Registered Nurse #2 documented that they were notified by a unit Licensed Practical Nurse that Resident #10 remained out of clozapine. The progress note included that the pharmacy required a provider to update the Risk Evaluation and Mitigation Strategy program (a requirement for monitoring the severe risk for neutropenia [abnormal white blood cell count] prior to refilling clozapine prescriptions). In a medical progress note dated 1/8/24, Nurse Practitioner #2 documented that they had been working on getting Resident #10 reapplied to the Risk Evaluation and Mitigation Strategy program since late December and that the blood work would be reordered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 12:16 PM, Registered Nurse Manager #1 said that when the provider (Physician) orders lab work, the nurses are supposed to collect the lab draws in-house on Tuesdays and Thursdays, call the hospital for the labs to be picked up and within 24 hours, the lab results should be available. Additionally, Registered Nurse Manager #1 said a paper copy of the labs would come through a fax and be reviewed by a nurse and the provider before being scanned into the resident's electronic health record. During an interview on 6/28/24 at 9:49 AM, Physician #1 stated that they were not sure what happened with the clozapine medication for Resident #10 between 12/30/23 and 1/10/24 and stated that the pharmacy would not fill the prescription until blood tests were completed. Physician #1 stated that clozapine was an antipsychotic medication and that it was an important medication for Resident #10 for behaviors and psychiatric issues. During an interview on 6/28/24 at 11:39 AM, Licensed Practical Nurse Manager #2 stated that Resident #10 was on a different unit at that time and that they were unaware of the circumstances of what occurred other than the medication was not refilled due to the bloodwork not being done and that the Nurse Manager at that time was no longer at the facility. In an interview on 6/28/24 at 12:49 PM, the Acting Director of Nursing stated that the medical providers should be responsible for a resident's required blood work and that all residents taking clozapine should have a standing order for blood work. The Acting Director of Nursing did not know who at the facility was responsible for the Risk Evaluation and Mitigation Strategy Assessments. 10 NYCRR 415.12(m)(2)

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	335439	A. Building B. Wing	06/28/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45200 Based on observations and interview conducted during the Recertification Survey, it was determined that the facility did not properly dispose of garbage and refuse. Specifically, garbage and refuse were not contained within dumpsters and receptacles were not covered. The findings are: Observations during the exterior tour of the facility on 6/24/24 at 11:42 AM included three dumpsters with one uncovered located on the northwest corner of the property. Additionally, there was trash around and behind the dumpsters including, but not limited to: part of a lift chair, plastic gloves, various paper and plastic items, and an empty medication blister pack displaying a resident's name and drug information. During an interview following this observation, the Acting Director of Nursing was given the medication blister packet and stated that it should have been shredded, not put in the garbage. Observations on 6/27/24 at 9:24 AM included two of the three dumpsters were left with the covers open. 10 NYCRR: 415.29 (i)(1), 415.29(j)(6)(i), 415.14(h), Subpart 14-1.150

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45200 Based on observations and record review conducted during the Recertification Survey, it was determined that the facility did not ensure compliance with all applicable State codes. Specifically, the facility was not in compliance with section 915 of the 2015 edition of the International Fire Code as adopted by New York State, which requires the use of carbon monoxide detection in a building that has fuel-burning appliances. The findings are: On 6/24/24 at approximately 9:00 AM, a carbon monoxide detector was observed in the basement kitchen above the prep sink area, and the kitchen was also observed to contain a natural gas-powered range. Further observations in the basement included natural gas boilers in the boiler room and a natural gas-powered generator in the generator room. Observations on 6/26/24 from 10:46 AM to 11:05 AM included carbon monoxide detectors located on the walls in the corridor on the second floor outside resident rooms [ROOM NUMBERS]. On 6/26/24 at 10:39 AM, the surveyor requested a list of documentation from the facility via email including documentation of testing of carbon monoxide detectors. There was no documentation provided by the facility of the locations of all carbon monoxide detectors within the facility or any documentation of monthly inspection and testing of carbon monoxide detectors. The 2015 edition of the International Fire Code (IFC), requires carbon monoxide detection to be provided in an approved location between the fuel burning appliance and the dwelling unit, sleeping unit, or classroom; or on the ceiling of the room containing the fuel-burning appliance. Additionally, carbon monoxide alarms shall be maintained in accordance with NFPA 720. The 2012 Edition of NFPA 720, Standard for the Installation of Carbon Monoxide Detection and Warning Equipment, requires that single-station carbon monoxide alarms shall be inspected and tested in accordance with the manufacturer's published instructions at least monthly. 10 NYCRR: 415.29(a)(2), 711.2(a)(1); 42 CFR: 483.70(b), 2015 IFC: Section 915, 915.1, 915.1.4, Section 1103.9, 2012 NFPA 720: 8.7.1

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46880 49368 Based on observations, interviews, and record review conducted during the Recertification Survey, it was determined the facility did not ensure that resident-identifiable information was kept confidential. This was observed on two (second and third floor residential care units) of three units and outside the facility by the garbage receptacle. Specifically, there were several observations of empty medication blister packets (a way to package medications) with resident identifiable information on them in open bins on the units and accessible to all staff, residents, and visitors. Additionally, a medication blister packet with resident identifiable information on it was observed outside the facility on the ground next to a garbage receptable also accessible to the public. The facility's undated policy, Health Insurance Portability and Accountability Act Compliance and Resident Identification Information Destruction, documented that resident identification information included personal identification details and any other documents containing protected health information. The policy documented all items containing resident identification information must be disposed of using the designated bins (for shredding) located throughout the facility that will be collected and contents securely shredded by a certified document destructive service. Under no circumstances should items containing resident identification information be disposed of in regular trash or recycling bins. All employees were responsible for ensuring that documents containing resident identification information were placed in the bins immediately after they were no longer needed, and employees must not leave documents containing resident identification information in unsecured areas or unattended. During observation on 6/24/24 at 11:42 AM, an empty medication blister packet that had a resident's name and medication clearly visible on the front of the packaging was located on the ground near the garbage dumpsters. When interviewed at the time, the acting Director of Nursing stated that the medication packet should have been shredded, not put in the garbage. During an observation on 6/26/24 at 12:25 PM, on the third-floor residential care unit there were approximately 16 empty medication blister packets labeled with resident's names and medication information in an open recycling bin in the unsecured nurse's station accessible to residents, all staff, and visitors. When observed on 6/27/24 at 9:52 AM, the same bin continued to contain multiple medication blister packets all with resident's identifying information visible on them. During an observation on 6/27/24 at 10:30 AM, on the second-floor residential care unit, there were multiple medication blister packets labeled with resident's identifying information visible on the packets in a recycling bin in the unsecured nurse's station accessible to residents, all staff, and visitors. During an interview on 6/27/24 at 9:52 AM, Licensed Practical Nurse Unit Manager #1 stated the contents in the recycling bin located in the nurse's station were picked up by environmental services to go to another location for shredding from an outside company. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 6/27/24 at 9:56 AM, Licensed Practical Nurse #1 stated when the medication blister packets were empty, the tops should be removed (contains resident's name and medication information) and scratched off with a marker and then placed in the recycling bin. During an interview on 6/28/24 at 10:39 AM, the Environmental Service Supervisor stated that the bins located at the nurse's station contained important papers that have patient identifying information on them that should not be thrown out but should be placed in special bins to be shredded. Environmental Service Supervisor stated that the top of the medication blister packet (containing resident identifiers) should be given to the nurses to be placed in a bin for shredding and these bins were located on the first floor and in the Business Office. During an interview on 6/28/24 at 12:49 PM, the acting Director of Nursing stated that resident's medication labeled blister packets were considered resident identifiable information and the process for disposing them should be to remove the top portion that has resident-identifiable information on it and placed in a bin designated for protected health information, and the other part can be thrown into the garbage. The acting Director of Nursing stated this information should be in a concealed area and not in an open area that was accessible to residents and visitors and that there was a bin designated for protected health information, on the first floor. 10 NYCRR 415.22(c)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 26883 Based on observations and interview conducted during the Recertification Survey, the facility did not properly maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. Specifically, laundry equipment was not maintained in proper working condition. The findings are: Observations in the basement laundry room on 6/25/24 at 8:40 AM included one of two dryers and one of three washing machines were not functional. When interviewed at this time, a housekeeping/laundry staff member stated that all of the laundry is done in-house, and it would help to have them all working. 10 NYCRR: 415.29, 415.29(b), 415.29(c)