STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335439	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE PEARL NURSING CENTER OF ROCHESTER	1335 PORTLAND AVE 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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the Recertification Survey, it was determined that for one (Resident #83) of one resident reviewed, the facility did not provide services with reasonable accommodation of resident's needs and preferences directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being to the extent possible. Specifically, the resident was not toileted per their preferences. This is evidenced by the following: Resident #83 has [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 8/19/20, revealed the resident was cognitively intact, required extensive assist of staff for toileting, and was always incontinent of bladder and bowel. The Comprehensive Care Plan and the current Certified Nursing Assistant (CNA) Kardex included that the resident had a self-care deficit related to a stroke, was able to be transferred using the APEX standing frame with extensive assist of one staff (dated as revised on 6/11/20), under toileting required two staff assistance at bed level for a check and change every two to three hours and as needed (dated as revised on 4/17/20), and that the resident prefers a bedpan at the side of the bed when in bed. In an interview on 9/9/20 at 10:55 a.m., the resident was in their room in their wheelchair, waved the surveyor down, and requested to be assisted to use the bathroom. The CNA was notified at that time and told the resident to go in their brief and they would put them back to bed to change their brief. When interviewed at that time, the CNA stated that the resident was transferred with a Hoyer lift and that they had been asking a lot lately to go to the bathroom. When asked about the ability to stand using the APEX stand lift, the CNA stated he would have to go off the unit to find one to transfer the resident. He said the resident was not careplanned for the stand lift for toileting, only for transfers. When interviewed on 9/9/20 at 2:01 p.m. and again on 9/11/20 at 11:00 a.m., the resident said that they were able to stand and would prefer to go to the bathroom on a toilet or a commode as opposed to in their brief. The resident said that they need to go often as they take a water pill. In an interview on 9/10/20, the Director of Therapy stated that the resident was evaluated by therapy in June, upgraded to a stand lift for transfers, and the care plan was revised for transfers but not toileting. He said there was no documentation related to evaluation or pertaining to toileting and that the therapist no longer worked at the facility. The Director said that if a resident can stand for transfers, he could not see any reason why they could not be transferred to a toilet or commode for toileting which would certainly be more dignified. In a second interview on 9/11/20 at 11:01 a.m., the CNA said that they could try the stand lift for toileting as the resident does not like having bowel movements in their brief and has a history of skin breakdown that has recently healed. When interviewed on 9/14/20 at 2:15 p.m., the Licensed Practical Nurse Manager stated that she did not know the resident was asking to use the toilet. She said staff should not be using the Hoyer if the resident is able to stand but they do not have a stand lift for each floor. She said the resident did well with the stand lift the previous week when they used it (after surveyor intervention), and she would ask for a therapy referral to assess the use of a commode. (10 NYCRR 415.5(e)(1))
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** Based on observations and interviews during the Recertification Survey, it was determined that for three (first, second and third floors) of three resident sleeping floors and one of one basement, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, there were dirty shower rooms, missing and stained ceiling tiles, water leaks, a dirty sit-to-stand lift, non-functioning light fixtures, a loose handrail, soiled resident items, and a broken heater cover. This is evidenced by the following: 1. Observations during the initial tour of the facility on 9/8/20 from 12:48 p.m. to 2:37 p.m. revealed the following: a. There was black, pink, and brown residue, mold, and mildew along the base of the floor and wall located in the shower stall of the third floor shower room closest to room [ROOM NUMBER]. b. The ceiling tiles in front of and inside the third floor clean and soiled utility room were stained brown and/or bowed. In the soiled utility room there was a missing ceiling tile and water was dripping down near the hopper. An interview with a Certified Nursing Assistant revealed the area always drips when it rains. c. There was a missing ceiling tile in the second floor clean utility room, and one of the ceiling lights was not working. d. There was a 'Best-Care' sit-to-stand lift in the hallway outside room [ROOM NUMBER], and the footrest was heavily soiled with crumbs, debris, dust, and residue. e. The handrail on the half-wall next to the first floor soiled utility room was loose from the wall and propped up by two pieces of wood that were leaning. f. A ceiling light fixture in the hallway outside the first floor soiled utility room was missing the lens cover and one of the two bulbs was out. g. There were two lights that did not illuminate when turned on that were located in the first floor shower room nearest room [ROOM NUMBER]. h. There was a ceiling tile missing in the corridor alcove located across from the first floor staff restroom, which exposed a section of structural steel beam that had fireproofing material on it. i. There was black and brown residue, mold, and mildew along the base of the floor and wall located in the shower stall of the first floor shower room closest to room [ROOM NUMBER]. Additionally, many of the ceiling tiles were stained brown, and there was discarded bloody gauze, iodine wipes, soiled paper towels, and a bar of soap in a green lift tub. 2. Observations on 9/9/20 at 9:40 a.m. revealed a water leak coming from a drainpipe in the ceiling of the basement generator room. The leak was directly above electrical boxes and fan switches, and a plastic bag was around the leaking pipe diverting water into a bucket below. There was no evidence of water damage to the electrical boxes or fan switches. 3. Observations on 9/9/20 at 9:45 a.m. revealed a water leak coming from a drainpipe in the basement behind the ice machine. The water was observed to be pooling on the floor in a depression area and diverting to a floor drain in the boiler room nearby. An interview with the Maintenance Director revealed that about two weeks ago they had to have a vendor snake the drains and that is when the leaks started. 4. Observations on 9/9/20 at 9:48 a.m. revealed a water leak coming from the ceiling in the basement wheelchair and therapy storage room. The ceiling of this room had bowed, stained, and missing ceiling tiles, and there was pooled discolored water on plastic bins containing therapy equipment including, but not limited to, wheelchairs, pads, forks, and spoons. 5. Observations on 9/9/20 at 11:25 a.m. revealed the cover to the HVAC Ptac unit in room [ROOM NUMBER] was damaged and falling off the unit. (10 NYCRR: 415.29, 415.29(i)(1)(2), 415.29(j)(1))
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the Recertification Survey, it was determined that for one

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

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F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (Resident #94) of one resident reviewed, the facility did not provide the treatment and services in the resident's plan of care to maintain functional ability. Specifically, the resident was not consistently ambulated by staff per the resident's individualized plan of care. This is evidenced by the following: Resident #94 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 8/13/20, included that the resident had severely impaired cognition and required extensive assist of staff for ambulation. The Comprehensive Care Plan (CCP), dated as last revised on 8/14/20, and the current Certified Nursing Assistant (CNA) Kardex included that the resident has limited physical mobility. Interventions documented in the ambulation section included contact guard up to 75 feet using a four-wheeled walker and wheelchair to follow, and to encourage ambulation throughout the day with staff assist. The CCP also included that the resident was at risk for falls with a history of multiple falls in the past year. Review of the Physical Therapy Discharge Summary, dated 8/25/20, revealed that the resident was on therapy for difficulty in walking and unsteadiness on feet. The resident was being discharged from therapy and was able to ambulate on level surfaces 100 feet with a four-wheeled walker and contact guard assistance. Review of the Point of Care (computer documentation of activities of daily living by the CNAs every shift) since discharge from therapy 19 days ago revealed that the resident ambulated in the hall on seven occasions with staff assistance and three times independently. There was no documentation under rejection of care. Review of the Floor Ambulation Program Flowsheet revealed that the resident was not on the walking program. In an interview and observation on 9/8/20 at 2:13 p.m., the resident stated that they want to walk more but they will not let him. The resident said they will not let them walk alone, and they do not have time to go with them. The resident was sitting in their wheelchair and a wheeled walker was in the room. When interviewed on 9/11/20 at 10:25 a.m. and on 9/14/20 at 11:47 a.m., the Director of Therapy stated that the resident was on therapy due to falls and was a risk to be on the walking program with just one aide. He said that when a resident discharges from Physical Therapy, they inform staff on what the resident can do, and floor staff should follow the care plan. The Director of Therapy said that the resident should not be independent. He said that the resident cannot walk 100 feet in their room and should be encouraged to walk in the hallway with a contact guard and a wheelchair to follow several times a day to maintain their strength. When interviewed on 9/11/20 at 1:57 p.m., the CNA stated the resident was alert and can walk in their room with help. The CNA said she has never seen the resident walk in the hallway. When interviewed on 9/14/20 at 2:01 p.m., the Licensed Practical Nurse (LPN) stated that the resident does not refuse care often and almost never with their regular aide (not available for interview). The LPN said that she has not seen the resident ambulate in the hallway very often. When interviewed on 9/14/20 at 2:15 p.m., the LPN/Nurse Manager stated that the resident's regular aide has been off but she should be documenting the resident's ambulation in the computer. She said if the resident refuses, it should be documented in the computer or in the progress notes. (10 NYCRR 415.12(a)(1)(ii))
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the Recertification Survey, it was determined that for one (Resident #95) of three residents reviewed, the facility did not provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice and the resident's care plan. Specifically, oxygen therapy was not provided per physician orders. This is evidenced by the following: Resident #95 was readmitted to the facility on [DATE] following an acute stay for hypoxic (low oxygen levels) [MEDICAL CONDITION] and [MEDICAL CONDITION] hypertension. The Minimum Data Set Assessment, dated 8/13/20, revealed the resident had severely impaired cognition and was on oxygen. The hospital discharge summary, dated 8/5/20, included the resident was being discharged on 5 liters of oxygen and to wean if possible. Physician orders, dated 8/5/20, included oxygen at 4 liters via nasal cannula continuous for [MEDICAL CONDITION]. The Comprehensive Care Plan, dated as last revised on 1/30/20, included that the resident had difficulty breathing related to anxiety, [MEDICAL CONDITIONS], and a history of [MEDICAL CONDITION]. Interventions included oxygen at 2 liters via nasal cannula continuously. The daily Resident Assignment/Shift Report, a report sheet used by Certified Nursing Assistants (CNA) and Licensed Practical Nurses (LPN) for assignments and reports included the resident's oxygen was at 3 liters continuously. Observations included the following: a. On 9/8/20 at 2:33 p.m., the resident's oxygen concentrator was set at 3.5 liters. The resident was in bed sleeping and did not arouse when their name was called. b. On 9/9/20 at 9:01 a.m., the resident's oxygen concentrator was set at 2.5 liters. c. On 9/10/20 at 1:48 p.m., the resident's oxygen concentrator was set at 3 liters. d. On 9/14/20 at 8:07 a.m., the resident's oxygen concentrator was set between 3 liters and 3.5 liters. The LPN/Nurse Manager (NM) was notified at that time and stated the oxygen should be at 3 liters, then she reset the oxygen. When interviewed on 9/11/20 at approximately 10:00 a.m., the CNA stated that the resident only takes their oxygen off to use the bathroom and was not known to play with the concentrator. The CNA said that the aides do not set the concentrator, the nurses do. In an interview on 9/14/20 at 8:11 a.m. and again at 2:15 p.m., the LPN/NM stated that she was not aware that the resident's orders for oxygen were at 4 liters or the CCP included oxygen at 2 liters. She said that it was very confusing and the nurses who are signing off on it should be checking the orders (or medication administration record) for the correct amount of oxygen. She said she would check with the Nurse Practitioner (NP) regarding the resident's oxygen orders. The LPN/NM later said that the NP requested the oxygen remain on 4 liters. (10 NYCRR 415.12(k)(6))