STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335341	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hurlbut	1177 East Henrietta Road Rochester, NY 14623

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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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the Recertification Survey from 07/24/2025 to 07/31/2025, the facility did not ensure each resident with pressure ulcers (ulcers on the skin due to prolonged pressure) received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infection for two (2) (Residents #43 and #95) of three (3) residents reviewed. Specifically, for Resident #43, staff did not follow physician's orders when completing a pressure ulcer treatment. For Resident #95, there was a lack of consistent weekly pressure ulcer assessments (including staging, measurements, or a description of the wound) and ongoing monitoring of a left medial ankle pressure ulcer. Additionally, assessments completed for Resident #95 had conflicting documentation to include treatment instructions and location of the pressure ulcer. The findings are:The facility policy Medication Orders, dated September 2011, documented each resident must be under the care of a Licensed Practitioner and treatment orders include the specific treatment, frequency, duration, and rationale of the treatment.The facility policy Skin Care Guidelines, dated April 2021, documented pressure injury documentation should include, but not limited to, location, dimensions (size of the wound), color of tissue inside the wound bed and surrounding tissue, edges of wound, presence of drainage or eschar (black or brown dead tissue), stage of wound, and presence of pain/lack of sensation. Additionally, wounds should be evaluated by the skin care team every week.1. Resident #43 had diagnoses including diabetes, sacral (lower back) pressure ulcer, and blindness. The Minimum Data Set (a resident assessment tool), dated 05/15/2025, documented Resident #43 had moderately impaired cognition, had an unstageable (full-thickness skin and tissue loss that is covered by dead tissue) pressure ulcer, received pressure ulcer care, and the application of nonsurgical dressings and ointments.The current Comprehensive Care Plan, initiated on 05/15/2025, included Resident #43 had open areas to their sacral region and right buttock. Interventions included to provide treatment to the area as ordered, skin observations per facility policy, and medical provider evaluation as needed. A current physician's order, dated 05/13/2025, included to cleanse the area with saline (a solution of salt and water used as a wound cleanser), pat dry, apply Santyl (topical medication used to help clean and remove dead tissue from skin wounds) and Alginate AG (wound dressing with antibacterial silver for draining wounds) to area with slough (nonviable wound tissue) and cover with a foam dressing every day shift. Review of Resident #43's July 2025 Medication and Treatment Administration Records revealed daily wound treatments on 07/21/2025, 07/23/2025, 07/24/2025, and 07/25/2025 were documented as 9 (other/see progress notes). Review of progress notes from 07/21/2025 to 07/25/2025 included the following:- On 07/21/2025 at 10:37 AM, Licensed Practical Nurse #3 documented resolved. Documentation did not include if a medical provider was notified. - On 07/23/2025 at 10:24 AM, Licensed Practical Nurse #2 documented area noted with no open areas. Documentation did not include if a medical provider was notified.- On 07/24/2025 at 11:47 AM, Licensed Practical Nurse #2 documented no open area noted. Documentation did not include if a medical provider was notified. - On 07/25/2025 at 4:41 PM, Licensed Practical Nurse #1 documented skin intact. Documentation did not include if a medical provider was notified. Review of a late entry (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(documentation of information that was omitted from the original record but is added later) progress note, dated 07/28/2025 at 1:00 PM, Physician Assistant #1 documented they had spoken to Licensed Practical Nurse Manager #1 and the wound on the coccyx (tailbone) area was closed and to discontinue the Santyl for the wound. Physician Assistant #1 documented the area had reopened but the tissue was pink, and no sloughing (dead tissue) was noted. Skin prep (protective film applied to the skin) and Allevyn (foam dressing) was placed on the area. During an interview and observation on 07/29/2025 at 11:14 AM, Licensed Practical Nurse #4 stated Resident #43 had a current wound treatment order for Santyl and Alginate and they had not done the daily dressing change yet. At 11:43 AM, Licensed Practical Nurse #4 prepared to complete the wound treatment. Resident #43 had an open wound to their sacrum, approximately two (2) to three (3) centimeters long and one (1) centimeter wide. Licensed Practical Nurse #4 cleansed the wound with saline, applied Santyl to the wound bed, and covered the wound with a foam dressing. Licensed Practical Nurse #4 stated they did not put the Alginate on the wound because it was used for wounds with slough. Licensed Practical Nurse #4 stated they wrote a note in the medical provider book (used by nursing staff to communicate resident concerns to the medical provider) to discontinue the Alginate, and they would write a progress note to explain why the Alginate was not applied. During an interview on 07/29/2025 at 12:56 PM, Licensed Practical Nurse Manager #2 stated wound treatments would be signed off on the Treatment Administration Record. Licensed Practical Nurse Manager #2 stated the nurses should follow the treatment order and if something was not needed for the wound or if the treatment was not done, they should notify a medical provider immediately and have them look at the wound. Licensed Practical Nurse Manager #2 stated on 07/28/2025, they were informed by the nurse that Resident #43's wound had reopened. They cleansed the wound and applied skin prep and a foam dressing. Licensed Practical Nurse Manager #2 stated they spoke with Physician Assistant #1 regarding the Santyl and Alginate no longer being appropriate as the wound bed was pink, Physician Assistant #1 said they would see the resident and agreed to the treatment change. Licensed Practical Nurse Manager #2 stated they forgot to document a progress note. When the electronic medical record was reviewed at this time, Licensed Practical Nurse Manager #2 stated the current treatment order was for Santyl and Alginate and a progress note, dated 07/24/2025, documented by Licensed Practical Nurse #2 included there was no open area, but they were unable to determine if the treatment was administered as ordered. During an interview on 07/30/2025 at 10:30 AM, Licensed Practical Nurse #3 stated on 07/21/2025, they looked at Resident #43's wound and it had resolved as there was no slough and no open wound. Licensed Practical Nurse #3 stated they could not recall if they told Licensed Practical Nurse Manager #2 the wound had resolved, and they did not notify a medical provider but should have.During an interview on 07/30/2025 at 10:42 AM, Physician Assistant #1 stated they would expect the nurse to follow orders when administering wound treatments and if there was a change or a question about the ordered treatment, they would expect the nurse to notify medical before they provide the treatment. Physician Assistant #1 stated Resident #43's sacral wound had slough approximately two (2) weeks prior, but had been notified the wound had changed on 07/29/2025. Physician Assistant #1 stated Resident #43's ordered wound treatment included Santyl, Alginate and a foam dressing and they were not notified the wound had resolved on 07/21/2025. Physician Assistant #1 stated they would expect to have been notified as Santyl and Alginate would not be indicated if the wound was no longer open. During an interview on 07/31/2025 at 9:28 AM, Administrator #2 stated the nurses should follow the wound treatment orders in the electronic medical record and if they identified a change in the wound, they should notify the nurse manager or team leader, and the medical provider. If there was a change to the treatment, the order should be changed at that time or immediately following. Administrator #2 stated during the wound treatment observation on 07/29/2025 at 11:43 AM, Licensed Practical Nurse #4 should have notified the nurse manager or medical provider that alginate was not applied as ordered. 2. Resident #95 had diagnoses including diabetes mellitus, atrial fibrillation (abnormal heart rhythm), and neuropathy (nerve damage that can (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cause numbness, tingling, pain). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment and one (1) stage two (2) (partial-thickness skin loss into but not deeper than the dermis) pressure ulcer that was not present on admission.The current Comprehensive Care Plan, initiated on 02/06/2025, documented Resident #95 had a stage two (2) pressure ulcer on the left medial ankle. Interventions included to administer treatments as ordered, monitor effectiveness, and follow facility policies/protocols for treatment of skin breakdown.Review of Resident #95's current Order Summary Report, dated 07/30/2025, included a treatment order to cleanse the left ankle wound with wound wash, pat dry, cover with a foam dressing, change every three days and as needed.Review of Resident #95's Wound Care Flow Sheets from 01/01/2025 to 07/30/2025 included the following Registered Nurse documentation:- On 01/30/2025, stage two (2) pressure injury medial left ankle, 1.1 centimeter x 0.9 centimeter. 100% granulation (formation of tissue in the process of healing) with a scant (very small) amount of bloody drainage.- On 07/02/2025, stage two (2) pressure injury left medial ankle, 1.5 centimeter x 0.8 centimeter. 100% granulation with a small amount of bloody drainage.Review of Resident #95's medical provider notes from 01/01/2025 to 07/29/2025 included the following documentation:- On 03/06/2025, open wound on left lower extremity, closely followed by the skin team, bleeding noted, dressing ordered. The note did not included measurements or staging of the wound.- On 03/20/2025, 03/25/2025, and 04/01/2025, stage two (2) chronic area on right lower extremity, wound bed is dry, 100% granulation, no redness, measuring 1.1 centimeter x 1 centimeter.- On 04/08/2025, stage two (2) chronic area on left lower extremity, eschar noted, no surrounding erythema (redness) or drainage, measuring 1.1 centimeter x 1 centimeter.- On 04/22/2025, 04/29/2025, 05/06/2025, 05/13/2025, 05/20/2025, 05/29/2025, 06/03/2025, and 06/10/2025, stage two (2) chronic area on right lower extremity, wound bed is dry, 100% granulation, no redness, measuring 1.1 centimeter x 1 centimeter.- On 07/02/2025, stage two (2) chronic area on left lower extremity, no improvement with increased measurements 1 centimeter x 1.7 centimeters, no erythema, partially scabbed and bleeding. Treatment changed to cleanse left ankle wound with wound wash, pat dry, cover with a foam dressing, and change every three days and as needed.- On 07/09/2025, stage two (2) chronic area on right lower extremity, wound bed is dry, 100% granulation, no redness, measuring 1 centimeter x 1 centimeter. Continue Triad (hydrophilic paste for light to moderate exudate [drainage] that helps maintain a moist environment for wound healing) to site and may cover with bordered gauze twice a day as needed only for bleeding.- On 07/30/2025, stage two (2) left ankle 1.7 centimeters x 1 centimeter, wound base pink and moist, small amount of bleeding from anterior (top) aspect, no surrounding redness, maceration (softened as a result of wetness), continue foam dressing.Review of the electronic medical record did not include documented evidence Resident #95's pressure ulcer to their left medial ankle was monitored and/or observed by the skin team or a medical provider for the weeks of 01/30/2025 to 03/06/2025, 03/06/2025 to 03/20/2025, 04/08/2025 to 04/22/2025, 06/10/2025 to 07/02/2025, and 07/09/2025 to 07/30/2025. Additionally, several of the assessments incorrectly documented the location of the pressure as the right lower extremity/ankle.During an observation on 07/30/2025 at 9:08 AM, Resident #95 had an open area on the left medial ankle with hyper-granulation tissue (an overgrowth of new tissue formed during the wound healing process) and active bleeding. Nurse Practitioner #1 wearing gloves only, placed unpackaged 4 inches x 4 inches gauze pads and wound cleanser directly on Resident #95's bottom fitted sheet of the bed. Nurse Practitioner #1 removed the old foam dressing from the left medial ankle and placed directly on the bottom fitted sheet of the bed, sprayed wound cleanser directly on the wound, dabbed the actively bleeding wound with several gauze pads, placed the contaminated pads directly on the fitted sheet of the bed, sprayed wound cleanser directly on the wound, dabbed the actively bleeding wound with several gauze pads, and placed the contaminated pads directly on the fitted sheet of the bed. Nurse Practitioner #1 then measured (1.1 centimeters x 1.7 centimeters) and placed a new foam dressing on the wound. During an interview on 07/29/2025 at 10:35 AM, Licensed Practical Nurse Unit Leader #1 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated pressure ulcer monitoring (skin rounds) is completed weekly with a team consisting of a medical provider, Unit Leader, and the Assistant Director of Nursing.During an interview on 07/29/2025 at 11:35 AM, Quality Care Coordinator #1 stated pressure ulcer monitoring should be completed weekly and include the location, measurements, progress, stage, and appearance (edges, wound bed, and any drainage) of wounds. During an interview on 07/29/2025 at 2:07 PM, Administrator #2 stated the 07/09/2025 medical provider recommendations for treatment of the left medial ankle stage two (2) pressure ulcer did not match the active physician's orders.During an interview on 07/30/2025 at 9:16 AM, Nurse Practitioner #1 stated pressure ulcer monitoring should be completed weekly, include the location, measurements, progress, stage, and appearance of wounds and treatment recommendations.During an interview on 07/30/2025 at 10:09 AM, Administrator #2 stated pressure ulcer monitoring should be completed weekly, and Resident #95's pressure ulcer was not monitored weekly.10 NYCRR 415.12(c)(2)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during a Recertification Survey from 07/24/2025 to 07/31/2025, the facility did not ensure pharmacist reported irregularities were reviewed by the attending physician and acted upon timely for two (2) (Residents #69 and #77) of five (5) residents reviewed. Specifically, the facility could not provide documentation supporting the consultant pharmacist's monthly recommendations were acted upon by the facility's Medical Director, attending physicians, or designees. For Resident #77 the facility could not provide evidence the Director of Nursing or an attending physician had reviewed the consultant pharmacist's recommendations for ten (10) of twelve (12) months reviewed, and for nine (9) of twelve (12) months reviewed for Resident #66. The findings are: The facility policy Pharmacy Services, dated November 2017, included the pharmacist would conduct a monthly drug regimen review for each resident in the facility. The pharmacist would report any irregularities (drugs that may be unnecessary or inappropriately dosed) to the attending physician, the Medical Director, and the Director of Nursing on a separate written report, and the reports must be acted upon. If the pharmacist identified an irregularity that required urgent action, they would immediately notify the Director of Nursing and the attending physician or the Medical Director.1. Resident #77 had diagnoses including dementia, depression, and adult failure to thrive. The Minimum Data Set (a resident assessment tool), dated 05/27/2025, documented the resident had severely impaired cognition and was taking an antidepressant. Review of Resident #77's current Comprehensive Care Plan, last revised 06/19/2025, revealed the resident received antidepressant medication related to depression. Resident #77's current physician's orders, dated 07/10/2025, included duloxetine hydrocholoride delayed release (a medication used to treat depression) 60 milligrams give one (1) tablet orally one (1) time daily.Review of the Consultant Pharmacist's Medication Regimen Reviews completed on 01/16/2025, 02/18/2025, 03/17/2025, and 05/21/2025 revealed recommendations from Pharmacist #1 to consider a taper (slowly decreasing the dose of a drug over time) attempt on duloxetine from 60 milligrams to 30 milligrams daily, and the last attempt occurred on 06/10/2024. Pharmacist #1 indicated a note was written to the physician. The facility was unable to provide documented evidence a medical provider received, reviewed, or acted upon the recommendations. Review of a Consultant Pharmacist's Medication Regimen Review, dated 06/22/2025, revealed Pharmacist #2 recommended a taper of duloxetine. A note to attending physician/provider, dated 06/22/2025, included the recommendation. Physician Assistant #1's response, dated 07/26/2025, included they disagreed with the recommendation, the duloxetine was used for neuropathy, and to leave as is.The facility was unable to provide medication regimen reviews from July 2024 to December 2024. During an interview on 07/30/2025 at 8:59 AM, Pharmacist #2 stated for Resident #77, they repeatedly recommended a gradual dose reduction (taper) each month for the resident's duloxetine hydrocholoride since October 2024 and a medical provider did not respond until May 2025. 2. Resident #68 had diagnoses including major depressive disorder, stroke, and insomnia. The Minimum Data Set, dated [DATE], revealed the resident had mildly impaired cognition and was taking an antidepressant.Review of Resident #68's current Comprehensive Care Plan, last revised 06/19/2025, revealed the resident received an antidepressant related to depression. Review of the Order Summary Report, dated 07/31/2025, included an active order for mirtazapine (a medication used to treat depression) 15 milligrams daily at bedtime and an order for trazodone (a medication used to treat depression, anxiety, and insomnia) 25 milligrams daily at bedtime, discontinued on 02/03/2025.Review of a Consultant Pharmacist's Medication Regimen Review, completed on 01/19/2025, revealed a recommendation from Pharmacist #1 to consider a taper attempt of trazodone. The facility was unable to provide documented evidence of a physician's response to the recommendation. Review of the Consultant Pharmacist's Medication Regimen (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviews, completed on 03/17/2025 and 04/23/2025, revealed consultant pharmacist recommendation for a taper attempt of mirtazapine from 15 milligrams to 7.5 milligrams at night. The facility was unable to provide documented evidence of a physician's response to the recommendations. A medication regimen review was completed on 05/21/2025 with a recommendation for a taper attempt of mirtazapine was not responded to by a provider until 06/30/2025. A medication regimen review completed in June 2025 with a recommendation for a taper attempt of mirtazapine was not responded to by a provider until 07/22/2025.The facility was unable to provide medication regimen reviews from July 2024 to December 2024. During an interview on 07/30/2025 at 8:59 AM, Pharmacist #2 stated for Resident #68, recommendations for a gradual dose reduction for the resident's trazodone had gone unanswered by a medical provider from November 2024 to January 2025. They stated in March 2025, they recommended Resident #68's dose reduction for mirtazapine and did not get a response from a medical provider until May 2025. Pharmacist #2 stated the process for medication reviews consists of consultant pharmacists reviewing the residents' electronic medical record monthly, checking for new physician's orders and indications for a gradual dose reduction (the process of identifying, decreasing, and potentially discontinuing the dose of a medication). Once the pharmacists determine their recommendations, a report is made and sent via email to the Assistant Director of Nursing, Administrator #1, Administrator #3, and the Medical Director. Pharmacist #2 stated there was a problem receiving provider responses to pharmacist recommendations since October 2024, and this past month they started receiving responses after the facility reportedly changed their monthly medication review process. During an interview on 07/30/2025 at 11:27 AM, Medical Doctor #1 stated monthly pharmacy recommendations are reviewed by the Nurse Practitioners and Physician Assistants who write their responses to the recommendations in a progress note. They stated the recommendations used to be communicated on paper and were sent to the Assistant Director of Nursing and then to the providers. Medical Director #1 stated they were only using progress notes to document responses to pharmacy recommendations. During an interview on 07/30/2025 at 11:34 AM with Physician Assistant #1 and Medical Doctor #1, Physician Assistant #1 stated they participate in meetings with nursing and doctors to review residents' medications and assess for the appropriateness of a gradual dose reduction. They stated the providers document their responses to a pharmacy recommendation in a progress note and sometimes received a sheet of paper they could write their responses on then return them to the Assistant Director of Nursing. Physician Assistant #1 stated the medical providers do not communicate directly with the pharmacists, but instead go through the Assistant Director of Nursing. During an interview on 07/29/2025 at 12:58 PM with Administrator #1 and Administrator #2, Administrator #2 stated pharmacy reviews were received and sent to the medical team for review monthly. Administrator #1 stated the facility had a peer review, completed June 2025, and they discovered the Consultant Pharmacist's Medication Regimen Reviews had not been reviewed by a medical provider. Administrator #1 stated they could not provide documentation of the Director of Nursing's review of the pharmacy recommendations monthly and they should have been reviewed by the medical team as they are a failsafe to ensure residents are getting the right medications at the right doses.During an interview on 07/31/2025 at 9:56 AM, the Director of Nursing stated they were aware the consultant pharmacist had brought up concerns with the monthly pharmacy review process in past Quality Assurance and Performance (QAPI) meetings and it was unclear what was being done with the recommendations. The Director of Nursing stated they would expect monthly pharmacy recommendations were received, reviewed, responded to timely, and uploaded to the electronic medical record. 10 NYCRR 415.18(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review conducted during a Recertification Survey from 07/24/2025 to 07/31/2025, for one (1) (Resident #52) of two (2) residents reviewed, the facility did not ensure a resident's environment remained as free of accident hazards as possible. Specifically, there were multiple observations of a bottle of pills labeled as zinc (a supplement that helps the immune system and metabolic function) left at Resident #52's bedside and there were no medical orders in place for the medication or to self-administer (the practice of an individual taking their own prescribed or over-the-counter medications independently, without direct assistance or supervision) the medication. Additionally, there was no documented evidence the resident had been reviewed by the interdisciplinary team for their ability to safely self-administer the medication or a comprehensive care plan in place to include measurable goals and interventions, for self-administration. The findings are:Review of the facility policy Self-Administration of Medications, dated 10/20/2024, included, but was not limited to, the interdisciplinary team would discuss if the resident was appropriate for self-medicating (self-administrating), document the results of their discussion in the resident progress notes, and review at least quarterly. Nursing would obtain an order from the medical provider for which medications were approved for self-medicating and the nursing staff would sign the medication administration record for medications taken by the resident. All medications for self-medicating must be locked in a storage area, such as a locked drawer in their room, where the resident could self-access. The Comprehensive Care Plan would indicate self-administration of medications. Resident #52 had diagnoses including low back pain, glaucoma (an eye disease that damages the optic nerve), and benign prostatic hypoplasia (an enlarged prostate). The Minimum Data Set (a resident assessment tool), dated 07/07/2025, documented the resident was cognitively intact. Review of Resident #52's current Comprehensive Care Plan, last revised 07/17/2025, did not include measurable goals or interventions related to the self-administration or storage of medications at the bedside.Review of Resident #52's current physician's orders on 07/28/2025, did not include orders for zinc, to self-administer medications, or to store medications at the bedside. During observations on 07/24/2025 at 10:11 AM and 07/28/2025 at 9:30 AM, there was an over-the-counter bottle of zinc on Resident #52's bedside table.During an observation and interview on 07/29/2025 at 10:02 AM, there was a half-full bottle labeled zinc and vitamin D3 tablets on Resident #52's bedside table. During an interview at this time, Resident #52 stated they took one (1) tablet daily and had been taking it for 50 years for their prostate. Resident #52 stated the nurses should know they were taking it because nurses had asked about the medication before. During an interview on 07/29/2025 at 11:14 AM, Licensed Practical Nurse #4 stated medications were stored in the medication carts and residents could self-administer medications if they had an order. Licensed Practical Nurse #4 stated Resident #52 had an order for medication to be left at the bedside and they would go back to check if the medications were taken or if the resident needed reminding. Licensed Practical Nurse #4 stated Resident #52's family brought a vitamin in, left it at the bedside, and the resident would take it every morning. Licensed Practical Nurse #4 reviewed the electronic medical record at that time and stated Resident #52 did not have a current order for the zinc and vitamin D3 that was in their room. Licensed Practical Nurse #4 stated they thought a medical provider knew the resident took the zinc because a provider had talked to the resident and their family about it.During an interview on 07/29/2025 at 12:56 PM, Licensed Practical Nurse Manager #2 stated Resident #52 did not have a current order for zinc and they were not aware the resident was self-administering the medication without an order. During an interview on 07/30/2025 at 10:42 AM, Physician Assistant #1 stated if residents or families brought medications from home, the medications should be sent to the pharmacy to verify the contents and there should be an order to self-administer medications. Physician Assistant #1 stated if nursing staff was aware the resident self-administered medication, a medical provider should have (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been notified. They stated they were only recently made aware Resident #52 self-administered zinc. During an interview on 07/31/2025 at 9:28 AM, Administrator #2 stated a medical provider should be aware and have orders in place for a resident known to self-administer and store a medication in their room.10 NYCRR 412.12 (h)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335341	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hurlbut	1177 East Henrietta Road Rochester, NY 14623

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review conducted during the Recertification Survey from 07/24/2025 to 07/31/2025, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Specifically, raw shell eggs were stored above ready to eat foods, there was bare-hand contact with ready to eat food, and there was a missing section of floor tile that was dirty. The findings are: Review of the undated facility policy Food Storage (item #11e - refrigerated storage) included cooked foods must be stored above raw foods to prevent contamination. Raw animal foods should be separated from each other and stored on lower shelves (below cooked foods or raw fruits and vegetables) and in drip proof containers.During an observation on 07/24/2025 at 8:55 AM, there was a cardboard box with crates of raw shell eggs stored on the third shelf of a wire storage rack directly above a pan with plastic wrapped thin-sliced ready to eat meats (ham and salami) inside the walk-in cooler in the main kitchen. During an observation on 07/24/2025 at 9:01 AM, there was a 3 foot x 3 foot section of flooring that was missing tiles under the right side of the three (3)-bay sink in the main kitchen. The section of missing tiles was also observed to be dirty and discolored with food debris. During an observation on 07/24/2025 at 12:42 PM, Food Service Worker #1 used bare (ungloved) hands to hold, cut, and place a sandwich on a plate for Resident #47 during lunch service in the main dining area. In an immediate interview, Food Service Worker #1 stated they were trained not to wear gloves while handling food and the last training was in March 2025. During an observation on 07/25/2025 at 11:44 AM, crates of raw shell eggs were again observed to be stored over a pan of thin-sliced meats in the kitchen walk-in cooler. During an interview at this time, the Food Service Director stated they were not sure who stored the eggs that way, but they should have been stored on the bottom shelf. The Food Service Director also stated that they believed the floor tiles had been missing for a month and the tiles had been ordered for replacement. During an interview on 07/30/2025 at 8:26 AM, Food Service Director stated sandwiches would be wrapped in plastic, should be presented to residents with gloved hands, and when unwrapped, the sandwich should not be handled with bare hands. 10 NYCRR: 415.14(h), Subpart 14-1.30, 14-1.40, 14-1.43(c), 14-1.80, 14-1.110(d), 14-1.170

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a Recertification Survey from 07/24/2025 to 07/31/2025, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) (Residents #43 and #95) of three (3) residents reviewed for pressure ulcers. Specifically, Resident #43 was on enhanced barrier precautions (techniques used to prevent transmission of infectious disease utilizing gloves and gowns with all high-contact care) and staff were observed providing wound care without the appropriate personal protective equipment (gown). Resident #95 did not have enhanced barrier precautions signage outside their room and staff were observed providing hands on care without appropriate personal protective equipment (gown and gloves). Additionally, there was lack of hand hygiene and glove changes during wound care for Resident #95. The findings are:The facility policy Enhanced Barrier Precautions, dated August 2024, included enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multidrug resistant organism as well those at increased risk of multidrug resistant organism acquisition (for example-residents with wounds or indwelling medical devices). High-contact activities/interactions included, but were not limited to, wound care and transferring. Residents determined to need enhanced barrier precautions will have signage posted on the outside of the individual's room indicating the type of precautions and recommended personal protective equipment.The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 04/28/2025, documented gloves should be changed and hand hygiene performed before moving from a contaminated-body site to a clean body-site during resident care.1. Resident #43 had diagnoses including a stage two (2) pressure ulcer to the sacral region (bottom area of the spine), hemiplegia/hemiparesis (weakness or partial paralysis on one side of the body), and diabetes. The Minimum Data Set (a resident assessment tool), dated 05/15/2025, documented the resident had moderately impaired cognition, had an unstageable (full-thickness skin and tissue loss that is covered by dead tissue) pressure ulcer, and received pressure ulcer care. The current Comprehensive Care Plan, revised on 05/15/2025, included Resident #43 was on enhanced barrier precautions secondary to a pressure ulcer to the sacral area and right buttock. Review of the Order Summary Report, dated 07/30/2025, included several orders for wound treatments. There were no current orders for enhanced barrier precautions.During an observation on 07/24/2025 at 9:18 AM, there was an enhanced barrier precaution sign on Resident #43's room door and a cabinet with personal protective equipment nearby in the hallway.During an observation and interview on 07/29/2025 at 11:43 AM, Resident #43 was in bed, Licensed Practical Nurse #4 was wearing gloves (no gown) and performed wound care to Resident #43's sacral and buttock area. After wound care was performed, Licensed Practical Nurse #4 saw the sign on Resident #43's door for enhanced barrier precautions and stated they should have worn a gown, but they forgot to do so.During an interview on 07/31/2025 at 9:28 AM, Administrator #2 stated enhanced barrier precautions were used for residents with any open areas on their skin, there would be a sign on the resident's door, and the staff should wear gowns and gloves when providing care. Administrator #2 did not know why the staff did not wear a gown when performing wound care.2. Resident #95 had diagnoses including diabetes, atrial fibrillation (abnormal heart rhythm), and neuropathy (nerve damage that can cause numbness, tingling, pain). The Minimum Data Set, dated [DATE], documented Resident #95 had moderately impaired cognition and a stage two (2) (partial-thickness skin loss into but not deeper than the dermis) pressure ulcer that was not present on admission.The current Comprehensive Care Plan, initiated on 02/06/2025, documented Resident #95 had a stage two (2) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer on the left medial ankle. Interventions included to administer treatments as ordered, monitor effectiveness, and follow facility policies/protocols for treatment of skin breakdown. The Comprehensive Care Plan did not document the Resident #95 was on enhanced barrier precautions.Review of Resident #95's current Order Summary Report, dated 07/30/2025, revealed a current order for a wound treatment. There were no current orders for enhanced barrier precautions.During an observation on 07/30/2025 at 9:08 AM, Resident #95 had an open area on the left medial ankle with hyper-granulation tissue (an overgrowth of new tissue formed during the wound healing process) and active bleeding. Nurse Practitioner #1 wearing gloves only, placed unpackaged 4 inches x 4 inches gauze pads and wound cleanser directly on Resident #95's bottom fitted sheet of the bed. Nurse Practitioner #1 removed the old foam dressing from the left medial ankle, placed it directly on the bottom fitted sheet of the bed, sprayed wound cleanser directly on the wound, dabbed the actively bleeding wound with several gauze pads, placed the contaminated pads directly on the fitted sheet of the bed, sprayed wound cleanser directly on the wound, dabbed the actively bleeding wound with several gauze pads, and placed the contaminated pads directly on the fitted sheet of the bed. Nurse Practitioner #1 then measured and placed a new foam dressing on the wound. Nurse Practitioner #1 did not change gloves or perform hand hygiene at any time during the wound dressing change. During an interview on 07/30/2025 at 9:16 AM, Nurse Practitioner #1 stated they were not concerned with placing the wound dressing supplies directly on the bottom fitted sheet of the bed, without a barrier, nor placing contaminated supplies directly on the bottom fitted sheet of the bed, without a barrier. Nurse Practitioner #1 stated they did not directly touch the wound nor the inside of the new dressing and would change their gloves and perform hand hygiene if their gloves had been visibly soiled.During an interview on 07/30/2025 at 9:32 AM, Licensed Practical Nurse Infection Preventionist #1 stated during a wound dressing change, the person performing the procedure should gather the supplies, wash their hands and don gloves, remove old dressing, remove gloves, wash hands and don gloves, cleanse wound, remove gloves, wash hands and don gloves, and place the new dressing to the wound. They stated hand hygiene and glove changes are done at these times to prevent reintroduction of bacteria into the wound, and no supplies, clean or dirty, should be placed directly on resident bedding as there may be bacteria present.During an interview on 07/30/2025 at 10:09 AM, Administrator #2 stated during wound care ,supplies for the treatment should be placed on the over bed table and not directly on the residents' sheets secondary to an increased risk of contamination. Additionally, gloves should be removed and hand hygiene performed after removing the old dressing, after cleansing the wound, and prior to placing a new dressing on the wound.During an observation and interview on 07/31/2025 at 10:09 AM, Certified Nurse Aide #1 assisted Resident #95 to a sitting position in bed by placing one arm under the residents' legs and one arm around the residents' upper torso. Once in a seated position on the edge of the bed, Certified Nurse Aide #1 placed both arms around Resident #95's upper torso while Resident #95 placed their arms around Certified Nurse Aide #1, Resident #95 pivoted and sat in their wheelchair. There was no enhanced barrier precaution signage on Resident #95's room door and there was no personal protective equipment nearby in the hallway. During an interview at this time, Certified Nurse Aide #1 stated Resident #95 was not on enhanced barrier precautions because it was not on the care plan and there was no signage on the door or set-up (personal protective equipment) outside of door.During an interview on 07/31/2025 at 9:49 AM, Licensed Practical Nurse Infection Preventionist #1 stated any resident with chronic wounds should be on enhanced barrier precautions. They stated Resident #95 was removed from enhanced barrier precautions in April 2025 as their wound had healed. Licensed Practical Nurse Infection Preventionist #1 stated they were unaware the resident was still receiving dressing changes and should be on enhanced barrier precautions to reduce the risk of spreading infections.10 NYCRR 415.19(a) (1-3)(b)(4)