

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>335566                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>06/10/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>United Helpers Canton Nursing Home                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>205 State Street Road<br>Canton, NY 13617 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                 |
| F 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on record review and interviews, the facility failed to consult with the physician when there was a significant change in a resident's physical status for one of three residents (Resident #1) reviewed. Specifically, Resident #1 had an acute physical decline on 05/24/2026, including inability to swallow, unresponsiveness, and increased signs and symptoms of discomfort, and the physician was not notified of the resident's change in status. Resident #1 was subsequently hospitalized upon the family's request and diagnosed with sepsis (extreme response to infection). This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings are: The 09/05/2019 reviewed facility policy, Notification of Resident Change, documented the facility must immediately inform the resident; consult with the resident's physician; and the resident's legal representative when: a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening condition or clinical complications). Documentation of such notification would be documented in the proper location of the medical record. Resident #1 had diagnoses including Parkinson's Disease (progressive neurological disorder) and dementia (decline in mental ability). The Minimum Data Set (a resident assessment tool) dated 05/13/2026 documented the resident had severe cognitive impairment and required maximum assistance for activities of daily living. Resident #1's Medical Orders of Life Sustaining Treatment, signed 04/05/2026, documented do not attempt resuscitation (allow natural death), send to the hospital when medically necessary, use of intravenous fluids, determine use for feeding tube needs if the need arose, and use antibiotics to treat infections. The 05/24/2026 at 2:43 PM nurse progress note by Licensed Practical Nurse #11, documented Resident #1's Health Care Proxy was contacted and discussion about the resident's decline and possible need for end-of-life care. The Health Care Proxy wanted to set up a time to speak with the doctor. The doctor was aware and would discuss resident needs with the Health Care Proxy on [05/27/2026]. The 05/24/2026 at 8:40 PM nurse progress note by Licensed Practical Nurse #10, documented Resident #1 was unable to tolerate any liquid or oral medications during the shift, attempted crushed medications in pudding and the resident held in their mouth without initiating swallow. They were nonverbal and only groaned in response to attempts at communication or repositioning. After supper, the resident was transferred to bed. Resident #1 displayed facial grimacing and groaning with any movement, suggesting pain during repositioning, is non-rousable and does not respond to verbal or tactile stimuli beyond groaning. They would pass on to oncoming nurse to reposition resident every two hours and provide oral care as needed. The 05/25/2026 at 12:56 PM nurse progress note by Registered Nurse #9, documented Resident #1 was unable to tolerate any liquid or oral medications, attempted crushed medications in pudding and the resident held it in their mouth without initiating a swallow, no purposeful swallowing observed. They were nonverbal, groaned in response to attempts at communication or repositioning. After breakfast, the resident was transferred to bed. Resident #1 displayed facial grimacing and groaning with any movement, suggesting pain during repositioning, is non-rousable and does not respond to verbal or tactile stimuli beyond groaning. The 05/25/2026 at 10:53 PM nurse progress note by Registered Nurse #7, documented Resident #1 remained non-arousable, did not respond to verbal or (continued on next page)</p> |                                                                                        |                                                 |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>                                                   | <p>tactile stimuli, moaned and displayed facial grimacing when being touched or repositioned. The resident's relative was notified; they arrived and made decision to send the resident to the hospital for intravenous fluids due to not eating since 05/24/2026 at lunch and total fluids 11 ounces. Emergency services were notified at 7:30 PM, arrived at 8:00 PM and the family requested no chest compressions if the resident's heart stopped, only fluids, oxygen, and medications as necessary. The 12/09/2025 Physician Orders documented Tylenol Extra Strength, 500 milligrams, two tablets twice per day and as needed. The last documented administration was on 05/24/2026 at 11:00 AM. The 05/2026 Medication Administration Record for Tylenol documented:- on 05/24/2026 the 8:00 PM dose was not given due to condition;- on 05/25/2026 the 11:00 AM dose was not given due to condition; and- on 05/25/2026 the 8:00 PM dose was not given due to condition. There was no documented evidence of any other pain medication provided to the resident on 05/24/2026 and 05/25/2026. There was no documented evidence that a medical provider was notified when the resident's condition changed and they were unable to swallow or take any medications, including pain medication, for over 24 hours. During an interview on 06/02/2026 at 6:43 PM, Licensed Practical Nurse #10 stated they last saw Resident #1 on the 05/24/2026 evening shift. The resident was not very arousable and could not eat or drink. They spoke with Licensed Practical Nurse #11, who said they spoke with the physician and the family about the resident's decline. They did not know what the conversations fully entailed, and it was Licensed Practical Nurse #10's understanding that there were plans for the physician and family to further discuss care and needs. They did not notify the physician due to Licensed Practical Nurse #11 stating they had already contacted the physician. The resident showed signs of pain when being put back to bed and then appeared comfortable. When they could not take their medications, Licensed Practical Nurse #10 stated they notified the supervisor, and could not recall who it was. During an interview on 06/08/2026 at 1:58 PM, Certified Nurse Aide #13 stated they provided care to Resident #1 during the day shift on 05/25/2026. They noted the resident was in pain and notified the nurses but could not recall who. The nurse stated it was not time for medications. Later in the shift, Certified Nurse Aide #13 asked one of the nurses for assistance in repositioning, the nurse tried to give the resident medication in applesauce or pudding, and they would not swallow. The aide cleaned out the resident's mouth and provided oral care. During an interview on 06/02/2026 at 4:37 PM, Registered Nurse #9 stated that on the 05/25/2026 day shift, Resident #1 was assisted out of bed, to the scoot chair (specialized reclining wheelchair), and taken to breakfast. The resident just let the food run out of their mouth and did not attempt to swallow. They did not contact the provider as there was a referral for a speech evaluation for swallowing already completed. The resident grimaced with pain during movement and repositioning. They had an order for Tylenol for pain, but they were not taking oral medications at that time. They spoke with the doctor about skin treatment for Resident #1, but they did not discuss the pain or the inability to take their oral medications. During an interview on 06/03/2026 at 9:29 AM, Physician #12 stated they were made aware Resident #1's Health Care Proxy wanted to discuss end-of-life care on 05/27/2026. They were not made aware when the resident was not able to swallow or take their medications. The physician was not notified of any urgency regarding end-of-life care, or they would have gone to see the resident. The resident had been declining, and the physician was aware the family was discussing what they wanted to do and then they were going to discuss with the physician on 05/27/2026. If nursing staff had notified the physician on 05/25/2026 when the resident was not eating or drinking, they would have notified the family sooner to obtain consent for pain management. 10 New York Codes, Rules, and Regulations 415.3(2)(ii)(a)</p> |                                                                                        |                                                 |