

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  United Helpers Canton Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  205 State Street Road 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46276</p> <p>48052</p> <p>48895</p> <p>Based on record review, observation, and interview during the recertification survey conducted 8/6/2024-8/9/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 2 of 2 resident neighborhoods (North and [NAME] Neighborhoods). Specifically, hot water was not maintained at acceptable temperatures in the North and [NAME] neighborhoods; resident wheelchairs were soiled and in disrepair on the [NAME] Neighborhood; there were sticky floors in several areas of the North Neighborhood; and the kitchenettes on the North and [NAME] Neighborhoods were in disrepair.</p> <p>Findings include:</p> <p>The facility policy, Resident's Rights, dated 8/15/2017, documented residents of the facility had the right to live in a clean and safe environment.</p> <p>The facility policy, Maintaining and Monitoring Water Temperatures - SNF (Skilled Nursing Facility), dated 2/2021 documented the water temperature must be capable of attaining a temperature of 90 degrees Fahrenheit and must not attain a temperature more than 120 degrees Fahrenheit. A routine temperature check of the hot water temperature would be made at various points in the hot water system to verify that temperatures were in accordance with facility policy.</p> <p>The facility policy, Work Orders/Requests, dated 2/13/2024 documented repairs of any unsafe and failing equipment was completed in a timely manner, and facility staff used a maintenance work order system. The Maintenance Department would prioritize the maintenance work orders and keep the signed work order on file for at least one year.</p> <p>The electronic communication from the Administrator dated 8/8/2024 at 12:34 PM, documented the facility did not have written policy for floor cleaning, kitchenette cleaning, or housekeeping.</p> <p>The electronic communication from the Administrator dated 8/9/2024 at 12:10 PM, documented the facility did not have written policy for routine maintenance.</p> <p>(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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Water Temperatures Not Maintained:</p> <p>During observations on 8/6/2024, the following water temperatures were measured:</p> <ul style="list-style-type: none"> <li>- at 1:25 PM, the Oak Cottage shower room's water temperature was 123.5 degrees Fahrenheit.</li> <li>- at 1:28 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 123.4 degrees Fahrenheit.</li> <li>- at 3:30 PM, the Maple Cottage shower room's water temperature was 85.4 degrees Fahrenheit; and the Oak Cottage shower room's water temperature was 122 degrees Fahrenheit.</li> <li>- at 3:32 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 121 degrees Fahrenheit.</li> <li>- at 3:41 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 89 degrees Fahrenheit.</li> <li>- at 3:42 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 123.3 degrees Fahrenheit.</li> <li>- at 3:45 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 122.1 degrees Fahrenheit.</li> <li>- at 3:47 PM, the [NAME] Cottage shower room's water temperature was 126.2 degrees Fahrenheit.</li> <li>- at 3:51 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 87.4 degrees Fahrenheit.</li> </ul> <p>During an observation on 8/7/2024, the following water temperatures were measured:</p> <ul style="list-style-type: none"> <li>- at 1:38 PM, the [NAME] Cottage shower room's water temperature was 121.9 degrees Fahrenheit.</li> <li>- at 1:42 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 122.3 degrees Fahrenheit.</li> <li>- at 1:44 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 122.8 degrees Fahrenheit, verified by Physical Therapy Assistant #10.</li> <li>- at 1:53 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 120.3 degrees Fahrenheit.</li> <li>- at 2:22 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 81.7 degrees Fahrenheit.</li> <li>- at 2:23 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 81.4 degrees Fahrenheit, verified by Certified Nurse Aide #11.</li> </ul> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- at 2:30 PM, resident room [ROOM NUMBER]'s bathroom sink water temperature was 81.4 degrees Fahrenheit, verified by Certified Nurse Aide #11.</p> <p>During an interview on 8/6/2024 at 1:02 PM, Resident #40 stated the water in their bathroom was never hot and the water was cold for several days last week and this week.</p> <p>During an interview on 8/6/2024 at 4:28 PM with the Director of Building and Grounds, and the Maintenance Coordinator, the Director of Building and Grounds stated hot water flowed from the boiler through the mixing valve, and there was a different valve for each unit. The circulation order for the hot water on the North Neighborhood was Oak, Elm, Willow, and the Birch Cottage was last. The circulation order for cottages for the hot water on the [NAME] Neighborhood was [NAME], Ash, Cherry, and Maple was last. The acceptable temperature range for hot water was 110-120 degrees Fahrenheit in sinks. The Maintenance Coordinator stated they checked the temperatures in every cottage. On 8/6/2024, they tested the water in the shower rooms between 8:00 AM and 8:30 AM, there were no abnormal temperatures. If the temperature was higher than 120 degrees Fahrenheit, they would see what happened and continue to check the temperatures until they were normal. The Director of Building and Grounds stated 122 degrees Fahrenheit was not an acceptable temperature. Hotter water could be caused by back feed, and colder water could be caused by not letting the water run long enough. Depending on the time of day it could take a couple minutes to get hot water. If the water was too hot it could burn a resident. They stated had not received any complaints about hot water but had complaints about cold water. The Maintenance Coordinator stated that if the water was cold the residents could refuse bathing or be uncomfortable while bathing.</p> <p>During an interview on 8/7/2024 at 8:45 AM, Maintenance Worker #7 stated in the morning they ran the sink water to get the hot water out of the pipes because the water would be sitting in them all night. The boiler constantly circulated the water, so it did not cool off in the pipes. They ran the water then checked the temperatures to ensure they were in acceptable ranges for resident showers.</p> <p>During an interview on 8/7/2024 at 2:30 PM, Certified Nurse Aide #11 stated sometimes residents complained that the water was cool or cold. There was a resident they cared for that ran the water in their room for 20 minutes before they got warm water.</p> <p>During an interview on 8/9/2024 at 11:01 AM, the Administrator stated they were aware that variances were found in the water temperatures from hot and cold, some were close to 120 degrees Fahrenheit and could creep over. They made some adjustments to make sure the temperatures did not go over the 90-120 degrees Fahrenheit.</p> <p>During an interview on 8/9/2024 at 11:30 AM, the Director of Nursing stated staff made them aware of showers being too cold. If a resident complained about the water, it would not be home like.</p> <p>Wheelchairs In Disrepair:</p> <p>During an observation on 8/6/2024 at 10:34 AM, Resident #59's electric wheelchair was dirty with food substances.</p> <p>Resident #71's wheelchair was observed:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 8/6/2024 at 10:45 AM, the footrest was ripped in several places and the seat area was dirty with food substances.</p> <p>- on 8/7/2024 at 9:35 AM, the blue footrest was ripped in several places.</p> <p>- on 8/7/2024 at 10:13 AM, the black positioning cushion on the right side of the chair was soiled with food substances, and the footrest was ripped in several places.</p> <p>- on 8/8/2024 at 10:21 AM, the seat and the black positioning cushion were soiled with dried food substances.</p> <p>During an interview on 8/8/2024 at 10:24 AM, Housekeeper #15 stated they could not recall if they were instructed to clean equipment but if they saw that a wheelchair was dirty, they would wipe down the seat or armrest.</p> <p>During an interview on 8/8/2024 at 11:37 AM, Certified Nurse Aide #9 stated wheelchairs should be cleaned by all staff but was mostly done by the midnight shift when the residents were sleeping. It was not homelike to have a dirty wheelchair.</p> <p>During an interview on 8/9/2024 at 9:59 AM, Licensed Practical Nurse #8 stated anyone could clean a wheelchair, but the night shift staff was responsible for cleaning the wheelchairs. They stated Resident #59's wheelchair was not clean. Resident #71's wheelchair was always dirty and should be cleaned. It was not homelike to have unclean wheelchairs.</p> <p>During an interview on 8/9/2024 at 10:09 AM, Registered Nurse Manager #3 stated the midnight shift certified nurse aides were responsible for cleaning wheelchairs. The wheelchairs should be cleaned, as it was not homelike or dignified for the residents to have dirty wheelchairs.</p> <p>During an interview on 8/9/2024 at 11:30 AM, the Director of Nursing stated the midnight shift certified nurse aides were responsible for cleaning wheelchairs. Resident #71 frequently had a dirty wheelchair, and it was cleaned regularly. Accessories on the wheelchair should also be cleaned. It was important to create a homelike environment, and it was a dignity issue if the wheelchairs were dirty.</p> <p>Sticky Floors:</p> <p>The following observations of sticky floors were made on 8/6/2024:</p> <p>- at 9:46 AM, the floor in resident room [ROOM NUMBER] at the vestibule between the two sides.</p> <p>- at 9:49 AM, the floor in resident room [ROOM NUMBER]</p> <p>- at 9:52 AM, the floor in resident room [ROOM NUMBER]</p> <p>- at 9:56 AM, the floor in resident room [ROOM NUMBER]</p> <p>- at 10:08 AM, the floor in resident room [ROOM NUMBER]</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- at 10:16 AM, the floor in resident room [ROOM NUMBER]</li> <li>- at 10:19 AM, the floor in resident room [ROOM NUMBER]</li> <li>- at 10:34 AM, the floor in resident room [ROOM NUMBER] on side A</li> <li>- at 10:47 AM, the floor in resident room [ROOM NUMBER]</li> </ul> <p>- at 12:00 PM, there were sticky floors in the North Neighborhood in the back of the dining room near the countertop and windows.</p> <p>The following observations of sticky floors were made on 8/7/2024;</p> <ul style="list-style-type: none"> <li>- at 9:17 AM, in the Elm Cottage the floor in the dining room near the windows.</li> <li>- at 9:31 AM, in Birch Cottage the floor in the dining room near the windows, in front of the counter with cabinets.</li> <li>- at 12:18 PM, the floor in front of the nurses' station between Oak and Elm Cottages was sticky.</li> </ul> <p>During an interview on 8/9/2024 at 11:34 AM, Housekeeper #5 stated they were responsible for sweeping the floors, making rooms presentable, and using wet floor signs. If the floors were sticky they were supposed to use warm water with chemicals. They stated the stickiness might have been from a buildup of chemicals. They would use just hot water to help remove the buildup. They stated sticky floors were not homelike.</p> <p>During an interview on 8/9/2024 at 11:59 AM, the Maintenance Coordinator stated the process for cleaning the floor was to sweep then mop daily. The floors should not be sticky, it was not homelike. If staff noted the floors were sticky, they should let housekeeping know.</p> <p>Kitchenette Maintenance:</p> <p>The following observations were made in the North Neighborhood kitchenette on 8/6/2024 at 11:20 AM:</p> <ul style="list-style-type: none"> <li>- the cabinet door under the handwash sink was damaged (an approximate 2-inch section of the door was missing).</li> <li>- one of the drawers was missing the drawer front.</li> <li>- an upper cabinet located over the toaster was missing an approximate 3 feet by 1 foot access door.</li> <li>- the countertop near the handwash sink was water damaged and in disrepair.</li> <li>- hardware for two cabinets were not connected with doors and door handles were loose with missing screws.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/8/2024 at 2:40 PM, the Maintenance Coordinator stated when a work order form was completed for the Food Service Department, the department would be given the yellow completed work order form. They verified that a 4/1/2024 work order had been signed off as completed and a 4/2/2024 work order had been assigned to a maintenance worker for the North Neighborhood kitchenette. The Maintenance Coordinator stated they did not follow up after the repairs made to the North Neighborhood kitchenette on 4/3/2024. They stated they could not find any work orders for the issues identified in the [NAME] Neighborhood kitchenette pantry and was not aware of the damaged part of the lower cabinet door under the hand wash sink. The Maintenance Coordinator stated it was important that work orders were filled out and completed so the facility was maintained in a safe and comfortable environment for residents.</p> <p>10 NYCRR 415.29(j)(1)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46276</p> <p>48052</p> <p>Based on observation, record review, and interview during the recertification survey conducted 8/6/2024-8/9/2024, the facility did not ensure residents were free of any significant medication errors for 3 of 4 resident (Residents #9, #53, and #59) reviewed. Specifically, Residents #9 and #53 did not receive medications as ordered and the medical provider was not notified, and Resident #59 did not receive their medication for Parkinson's disease (a progressive neurological disorder) timely as ordered.</p> <p>Findings include:</p> <p>The facility policy, Medication Policies Program, revised 9/16/2024, documented all drugs were to be administered in compliance with the physician's orders, were administered safely, and were administered without error. The person who administered the medication would ensure the six rights of medication administration: the right person, the right medication, the right dose, the right time, the right method/route, and the right documentation.</p> <p>1) Resident #9 had diagnoses including depression, heart failure, and hypothyroidism (underactive thyroid). The 6/4/2024 Minimum Data Set (a health assessment tool) documented the resident had severely impaired cognition, appeared down, depressed, or hopeless for several days, had no behavioral symptoms, was dependent or required touching assistance for activities of daily living, and took an antidepressant and a diuretic (waterpill) medication daily.</p> <p>The 2/1/2023 Nurse Practitioner #16's medical order documented one furosemide (diuretic) 40 milligram tablet twice a day for heart failure at 7:00 AM and 1:00 PM.</p> <p>The 12/14/2023 Physician #17's medical order documented duloxetine capsule (antidepressant), delayed release, 30 milligrams once a day for depression at 7:00 AM.</p> <p>The 7/19/2024 Nurse Practitioner #16's medical order documented levothyroxine (thyroid medication) 137 micrograms one tablet once a day for hypothyroidism at 7:00 AM.</p> <p>The 8/7/2024 Medication Administration Record documented by Licensed Practical Nurse #2 included:</p> <ul style="list-style-type: none"> <li>- the 7:00 AM dose of duloxetine capsule, delayed release, 30 milligram was not administered due to the drug/item was unavailable.</li> <li>- the 7:00 AM dose of furosemide tablet 40 milligrams was not administered due to the drug/item was unavailable.</li> <li>- the 7:00 AM dose of levothyroxine tablet 137 micrograms was not administered due to the drug/item was unavailable.</li> </ul> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence the medical provider was notified of the medications that were not administered due to being unavailable.</p> <p>During an interview on 8/9/2024 at 9:10 AM, Licensed Practical Nurse #2 stated the electronic medical record prompted the nurses on what medications to give and then the nurse double checked the dose against the medication card (blister pack) to verify what medication to give and how much. If they did not have the required medication card in the cart, they checked the medication room to see if a refill card was there. If there was no medication card in the medication room, they checked the electronic stock medication supply system. If the medication was not available in the electronic stock medication supply system, they made sure they notified the pharmacy to resupply the medication either by clicking the button in the electronic medical record if applicable, or by faxing the pharmacy. They documented the medication was not given. If the medication was not given, they wrote a progress note in the resident's electronic medical record. If the medication was a significant medication they let the providers and the oncoming nurse know the medication was not given. They considered levothyroxine and furosemide to be significant medications. Duloxetine was a behavior or depression medication and was not as significant. They did not inform the provider that Resident #9 did not receive their duloxetine, levothyroxine, or furosemide as ordered on 8/7/2024. They stated 8/7/2024 was the day they did their cassette exchange, which meant pharmacy brought the new month's supply of medication, and they were out of quite a few medications. They did not believe anything could happen to the resident from the missed doses. At 10:34 AM, Licensed Practical Nurse #2 stated when the new cassettes came in on 8/7/2024, they did not give the missed doses of medication to the resident as the medications came in around 10-10:30 AM. Some of the medications had an afternoon dose and they did not want the doses to be too close together.</p> <p>2) Resident #53 had diagnoses including dementia with behavioral disturbances, depression, and type 2 diabetes without complications. The 6/5/2024 Minimum Data Set documented the resident had severely impaired cognition, had no behavioral symptoms, was dependent or required moderate assistance for most activities of daily living except, and took an antipsychotic (mood stablaizer) medication daily.</p> <p>The 11/16/2023 Nurse Practitioner #16's medical order documented Seroquel (antipsychotic) 25 milligram tablet, give 12.5 milligrams once a day at 6:00 PM for major depressive disorder.</p> <p>The Medication Administration Record documented on 8/5/2024 and 8/6/2024 the 6:00 PM dose of Seroquel 12.5 milligrams was not administered by Licensed Practical Nurse #18 due to the drug/item was unavailable.</p> <p>There was no documented evidence the medical provider was notified of the medications that were not administered due to being unavailable.</p> <p>During an interview on 8/8/2024 at 3:41 PM, Licensed Practical Nurse #18 stated they administered medications by pulling up the orders on the electronic medical record. Once the resident took the medication, they clicked off the order was completed in the medical record. If a resident refused their medications or the medications were not available, they marked it in the electronic medical record. They did not inform anyone because the information was on the electronic medical record the provider and nursing supervisor had access to so they would know if the resident took their medications or did not take their medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/9/2024 at 9:30 AM, Registered Nurse Unit Manager #3 stated if a resident refused their medication or missed their medication dose due to it not being in stock, they should be informed. It was not an acceptable practice to mark the medication was not given in the electronic medical record and not inform them, the nurse supervisor, or the medical providers. Levothyroxine, furosemide, duloxetine, and Seroquel were all significant medications. They were unaware that Resident #9 did not receive their levothyroxine, furosemide, and duloxetine as ordered on 8/7/2024 due to it not being in stock. They stated a missed dose of furosemide could lead to fluid overload and a missed dose of levothyroxine was important because it was thyroid related. They were unaware that Resident #53 did not receive their Seroquel on 8/5/2024 and 8/6/2024 due to it not being in stock. They stated missed doses of Seroquel could lead to behavior spikes and they needed to know the resident had missed doses when evaluating the resident's behaviors for medication changes. They stated the floor nurses should document a progress note in the electronic medical record the resident did not receive their medications as ordered and why, and that the Nursing Supervisor, the Nurse Manager, or the provider were made aware. The nurses were educated about informing the Nurse Manager/Nursing Supervisor or provider about missed medication doses.</p> <p>During an interview on 8/09/2024 at 10:14 AM, the Director of Nursing stated if a medication was not available or not in stock, the nurse should check the electronic stock medication supply system to see if it was available. The medication should immediately be reordered via the button in the electronic medical record. For any dose that was not given due to not having the medication in stock, the nurse should get an order to hold the medication. The nurses should make someone aware that a dose of medication was not given due to the medication not being in stock even if it is marked as not given in the electronic medical record. Levothyroxine, furosemide, and Seroquel were significant medications. Duloxetine was a significant medication, but the difference was a single dose did not treat immediate behaviors. 8/7/2024 was the day they received the new medication cards for the month and normally, if a resident was out of medications but the medication came, they would give the dose late. They were unaware Resident #53 had missed two doses of Seroquel on 8/5/2024 and 8/6/2024. They were unaware if Seroquel was stocked in the electronic stock medication supply system.</p> <p>3) Resident #59 had diagnose including Parkinson's disease and muscle weakness. The 6/26/2024 Minimum Data Set assessment documented the resident #59 was cognitively intact had no drug regimen review or medication follow-ups.</p> <p>The comprehensive care plan initiated 5/16/2024 documented the resident had Parkinson's Disease and required medication management to relieve or reduce the decline in activities of daily living. Interventions included determine assistance needed for activities of daily living, administer medications per physician order and monitor for side effects, report side effects to physician, and consult or meet with neurologist as needed.</p> <p>Physician orders documented:</p> <p>- on 7/23/2024 carbidopa-levodopa tablet; 25-100 milligrams; 2 tablets twice daily at 11:00 AM and 5:00 PM for Parkinson'r disease.</p> <p>- on 7/23/2024 carbidopa-levodopa tablet; 25-100 milligrams; 2 1/2 tablets teice daily at 8:00 AM and 5:00 PM for Parkinson's disease.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  United Helpers Canton Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  205 State Street Road 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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 7/24/2024 carbidopa-levodopa extended release; 25-100 milligrams; 2 tablets every day at 8:00 PM for Parkinson's disease.</p> <p>The 8/2024 electronic Medication Administration Record documented;</p> <p>- carbidopa-levodopa tablet; 25-100 milligrams, administer 2 1/2 tablet at 8:00 AM and 2:00 PM with a start date of 7/23/2024. The medication was documented as administered late on 8/1/2024 at 10:32 AM scheduled for 8:00 AM (2 hours, 32 mins); on 8/5/2024 at 9:35 AM scheduled for 8:00 AM (1 hour 35 mins); on 8/6/2024 at 9:47 AM scheduled for 8:00 AM (1 hour, 47 mins); on 8/9/2024 at 9:19 AM scheduled for 8:00 AM (1 hour, 19 mins); and 8/3/2024 at 3:23 PM scheduled for 2:00 PM (1 hour, 23 mins).</p> <p>- carbidopa-levodopa tablet; 25-100 milligrams, administer 2 tablets at 11:00 AM and 5:00 PM with a strat date of 7/23/2024. The medication was documented as administered late on 8/4/2024 at 12:20 PM scheduled for 11:00 AM (1 hour 20 minutes); and at 6:16 PM scheduled for 5:00 PM (1 hour, 16 mins).</p> <p>- carbidopa-levodopa tablet extended release; 25-100 milligrams; administer 2 tablets at 8:00 PM with a start date of 7/24/2024.</p> <p>During an interview on 8/6/2024 at 10:34 AM, Resident #59 stated they were happy living in the facility and their only complaint was their Parkinson's medication was given late. They stated they received carbidopa-levodopa five times a day and their doses were always late.</p> <p>During an interview on 8/9/2024 at 9:51 AM, Licensed Practical Nurse #8 stated Resident #59 had Parkinson's disease and received medication for this several times throughout the day. The medication times were set by the neurology clinic. They stated the electronic medical record time stamped when a nurse gave a medication. If it documented late administration or charted late that meant the medication was given late. The computer system would not let them continue until they clicked they administered the medication. They stated it was important to give Parkinson's medications on time as it could affect the resident's whole body.</p> <p>During an interview on 8/9/2024 at 10:09 AM, Registered Nurse Unit Manager #3 stated the electronic medication records had a preparation side and an administration side for medication administration. The nurses clicked on the prepped side, administered the medications to the resident, and then clicked on the administered button to complete the task in the electronic record. They stated medications nurses should not click administered until the resident took their medications just in case they refused them. If the electronic medication record documented 'charted late', then the resident received their medication late. If Resident #59's Parkinson's disease medications were not administered on time it could affect their blood pressure.</p> <p>During an interview on 8/9/2024 at 11:30 AM, the Director of Nursing stated after looking in the resident's electronic medical record, the resident received medication for Parkinson's disease several times per day. If Resident #59 did not receive their medications on time it could lead to an exacerbation of their Parkinson's disease symptoms and could affect their whole body.</p> <p>10NYCRR 415.12(m)(2)</p>		

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NAME OF PROVIDER OR SUPPLIER  United Helpers Canton Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  205 State Street Road Canton, NY 13617	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48052</p> <p>Based on observation and interview during the recertification survey conducted 8/6/2024-8/9/2024, the facility did not ensure drugs and biologicals were labelled and stored in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions when applicable for 1 of 4 medication carts (North neighborhood, Oak, and Elm Cart) reviewed. Specifically, the North neighborhood (the secured unit) Oak and Elm medication cart was left unlocked and unattended.</p> <p>Findings include:</p> <p>The facility policy, Medication Policies Program, revised 9/7/2016, documented medication rooms, medication cupboards, medication carts, and drug preparation areas would be kept clean, neat, and orderly at all times and the area would be kept locked unless under direct visual control by the staff person responsible for the medication administration. All mobile medication carts must be under visual control of the designated staff administering medications at all times.</p> <p>The following observations were made on 8/7/2024:</p> <ul style="list-style-type: none"> <li>- At 12:24 PM, the medication cart for Oak and Elm was in the dining room. The medication cart had the computer screen open with visible resident information and the cart was unlocked and unattended. There were residents in the dining room awaiting lunch.</li> <li>- At 12:26 PM, the top drawer of the medication cart was opened and then shut by the surveyor to verify the cart was unlocked. Licensed Practical Nurse #2 (the assigned medication nurse) was not near the unattended medication cart.</li> <li>-At 12:28 PM, Licensed Practical Nurse #2 came back to cart, shut the computer screen, and walked away from the cart. The cart remained unlocked and unattended.</li> <li>-At 12:31 PM, Licensed Practical Nurse #2 was sitting on a resident's four wheeled walker in the dining room with their back to the medication cart. The cart remained unlocked.</li> <li>-At 12:32 PM, Licensed Practical Nurse #2 walked behind the kitchenette, out of sight of the medication cart. The medication cart was unlocked and unattended.</li> </ul> <p>During an interview on 8/9/2024 at 9:10 AM, Licensed Practical Nurse #2 stated the top drawer of the medication cart contained insulin pens and eye drops, the second and third drawers contained prescribed medications in blister packs, the third drawer contained stock medications, and the bottom drawer had treatment powders and creams. They stated the medication cart should not be left unlocked. They stated they left the cart unlocked on 8/7/2024 as they got busy running around. Residents or anyone could get into the cart and take things out if it was unlocked and unattended.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  United Helpers Canton Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  205 State Street Road Canton, NY 13617	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/09/2024 at 9:30 AM, Registered Nurse Manager #3 stated nurses should not leave the medication carts unlocked. If a medication cart was unlocked the residents, or anyone could get into the cart. The nurses were constantly educated on not leaving their medication carts unlocked.</p> <p>During an interview on 8/9/2024 at 10:14 AM, the Director of Nursing stated nurses should not leave their medication carts unlocked. If a nurse walked away from their unlocked medication cart, someone could get into the cart and possibly take the medications.</p> <p>10 NYCRR 415.18(d)</p>		