

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER St Anns Community		STREET ADDRESS, CITY, STATE, ZIP CODE 920 Cherry Ridge Blvd Webster, NY 14580	
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641</p> <p>Based on interviews and record review conducted during a Recertification Survey, the facility did not ensure that newly admitted resident's and/or their representatives were provided with a written summary of a Baseline Care Plan that included the minimum healthcare information necessary to properly care for the immediate needs of the resident (including but not limited to initial goals, admission orders, dietary, therapy and social services) for 9 (Residents #2, #7, #31, #40, #53, #55, #56, #57 and #58) of 11 residents reviewed. Specifically for all residents identified the facility did not provide the resident or their representative with a summary of a Baseline Care Plan in a timely manner. This is evidenced by, but not limited to the following:</p> <p>The current facility policy, Care Planning-Interdisciplinary, dated 7/12/22, included a baseline care plan is initiated and completed with 48 hours of admission and developed before the comprehensive assessment. Prior to the scheduled care plan meeting a copy of the residents Baseline or their Comprehensive Care Plan, a medication list, and their care card (care plan used by the Certified Nursing Assistants for daily care) will be offered to the resident and/or designated family member. A note will be written into the electronic health record to confirm this information was provided.</p> <p>1. Resident #58 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and diabetes. The Minimum Data Set Resident assessment dated [DATE] included that the resident was severely impaired cognitively.</p> <p>Review of Resident #58's Care Plan Report (also known as a Comprehensive Care Plan or a Baseline Care Plan), dated 6/16/23, revealed no documented evidence that the Care Plan Report (utilized as a Baseline Care Plan) had been implemented within 48 hours of admission or that a written summary of their initial care needs (that included admission orders, dietary, therapy and social services) had been provided to the resident or their representative.</p> <p>Review of Resident #58's electronic health record from 5/25/23-present revealed no documented evidence that any summary of the resident's initial care (that included admission orders, dietary, therapy and social services) had been provided to the resident and/or the resident representative after admission to the facility.</p> <p>2. Resident #56 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (irregular heart rate), depression, and fall with a fracture. The Minimum Data Set Resident assessment dated [DATE] included that the resident was moderately impaired cognitively.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335730
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #56's Care Plan Report, dated 10/19/23, revealed no documented evidence that the Care Plan Report or a summary of care (that included admission orders, dietary, therapy and social services) was provided to the resident or the resident representative.</p> <p>In a Clinical Note Report dated 12/15/23, Social Worker #1 documented that Resident #56's and the resident's family were given copies of their care plan, their care card, and a medication list at the initial family meeting on 12/13/23, 55 days after the Care Plan Report was initiated.</p> <p>3. Resident #55 was admitted to the facility 2/15/24 with diagnoses including dementia, pressure ulcer of right foot, and diabetes mellitus. The Minimum Data Set Resident assessment dated [DATE] included that the resident was cognitively intact.</p> <p>Review of Resident #55's Care Plan Report, dated 2/15/24, revealed no documented evidence that a summary of care (including admission orders, dietary, therapy and social services) was provided to the resident or the resident representative.</p> <p>In a Clinical Notes Report, dated 4/15/24 Social Worker #1 documented that an initial family meeting was held on 3/27/24 and that the family was provided with copies of Resident #55's care plan, care card, and medication list (41 days after the Care Plan Report was initiated).</p> <p>During an interview on 5/8/24 at approximately 9:15 AM, Social Worker #1 stated that a Baseline Care Plan is done within 24 hours and that Social Work is responsible for providing it to the resident and/or family. Social Work #1 stated that there was no documentation in the electronic health record that the Baseline Care Plan had been offered until the initial care plan family meeting (for these residents). Social Worker #1 said that the Baseline Care Plan is converted to the Comprehensive Care Plan within 21 days and then that care plan is provided to the family at the initial care plan meeting (usually within 21 days) as the family would rather have the Comprehensive Care Plan instead of the Baseline Care Plan.</p> <p>During an interview on 5/8/24 at 11:18 AM, the Director of Nursing stated the Social Worker was responsible to make sure the resident and/or resident representative received a copy of the Baseline Care Plan.</p> <p>10 NYCRR 415.11</p> <p>49368</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey, for one (Residents #2) of one resident reviewed the facility did not ensure residents received treatment and care in accordance with professional standards of practice. Specifically, Resident #2 had several extended periods of time without a documented bowel movement, did not receive appropriate interventions to manage their bowel patterns, and did not have a comprehensive care plan in place to address a diagnosis of constipation. This is evidenced by the following:</p> <p>The facility policy and procedure, Bowel Management, date 1/28/19 included that Nursing would monitor the bowel regimen where appropriate and establish a care plan to ensure the Elder (Resident) was having regular bowel patterns. The electronic documentation system bowel management report would be reviewed daily. If an Elder had no bowel movement after more than six shifts, the staff nurse should initiate the as needed bowel regimen as ordered or notify the medical provider or supervisor. If the as needed regimen was started for no bowel movement and there were no results in 24 hours, the medical provider should be notified.</p> <p>Resident #2 had diagnoses including constipation, dehydration, and dementia. The Minimum Data Set Resident assessment dated [DATE] revealed the resident had moderately impaired cognition, was independent with toilet transfers, was always continent of bowel, and required assistance with toileting hygiene.</p> <p>Review of current physician orders included the following medications to treat constipation: sennosides-docusate sodium (stool softener + laxative) once daily, polyethylene glycol (laxative) once daily, Dulcolax (laxative) suppository daily as needed (for constipation), and magnesium hydroxide (laxative) once daily as needed (for constipation) and polyethylene glycol (laxative) once daily as needed (for constipation).</p> <p>Review of the current comprehensive care plan did not include measurable goals or interventions to address Resident #2's constipation or bowel management and did not address a history of, or current refusals of care. Review of the current Resident Care Summary (care plan used by the Certified Nursing Assistants for daily care needs) included to keep the toilet turned off and document bowel movements as necessary.</p> <p>Review of the bowel movement report (documentation of the resident's bowel movements, consistency and continence) in the resident's electronic medical record from 4/11/24 to 4/17/24 revealed Resident #2 had 16 consecutive shifts during this timeframe where no bowel movement had been recorded.</p> <p>Review of Medication Administration Records from 4/11/24 to 4/17/24 revealed routine medications to treat constipation were administered daily as ordered. Polyethylene glycol as needed was administered on 4/16/24 at 6:36 AM with no results documented.</p> <p>Review of a nursing progress note authored by Registered Nurse #2 on 4/16/24 at 2:54 PM, revealed Resident #2 had no bowel movements and a scheduled bowel medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note authored by Licensed Practical Nurse #3 on 4/17/24 at 1:15 PM, revealed that polyethylene glycol and prune juice had been administered at 9:30 AM after no bowel movements had been recorded for 17 shifts and results were pending. Resident #2 was also offered a Dulcolax suppository but refused the medication.</p> <p>Review of the bowel movement report from 4/25/24 to 4/30/24 revealed 11 consecutive shifts during this timeframe where no bowel movement had been recorded.</p> <p>Review of Medication Administration Record from 4/25/24 to 4/30/25 revealed routine medications to treat constipation were administered daily as ordered. Polyethylene glycol as needed was administered on 4/28/24 at 9:32 PM with no results documented. Magnesium hydroxide as needed was administered on 4/29/24 at 6:00 PM with no results documented.</p> <p>Review of a nursing progress note authored by Licensed Practical Nurse #4 on 4/29/24 at 7:42 AM, revealed Resident #2 had no recorded bowel movement for 10 shifts. The resident refused bowel medications that morning but had received an as needed dose of polyethylene glycol the previous evening with no results.</p> <p>Review of a nursing progress note authored by Licensed Practical Nurse #5 on 4/30/24 at 6:00 AM, revealed Resident #2 had no bowel movement in 11 shifts and refused bowel medications.</p> <p>Review of the bowel movement report from 5/1/24 to 5/6/24 revealed no documented bowel movements for 13 consecutive shifts.</p> <p>Review of the Medication Administration Record from 5/1/24 to 5/6/24 revealed routine medications to treat constipation were administered daily as ordered. There were no as needed bowel medications administered during this time.</p> <p>During an interview on 5/2/24 at 9:52 AM, Resident #2 stated they had been experiencing constipation and was taking polyethylene glycol but could not seem to find relief.</p> <p>During an interview on 5/6/24 at 11:57 AM, Licensed Practical Nurse #1 stated that Resident #2 received routine medications daily to treat constipation. Upon review of the bowel movement report at that time, Licensed Practical Nurse #1 stated the resident had not had a bowel movement for 18 shifts. Licensed Practical Nurse #1 stated that the Certified Nursing Assistants were responsible for documenting when a resident had a bowel movement, and that nursing should follow the bowel protocol after nine shifts with no bowel movement.</p> <p>During an interview on 5/6/24 at 12:30 PM, Certified Nursing Assistant #1 stated their responsibility was to document whether a resident had a bowel movement, the characteristics of the bowel movement, and if the resident was continent or incontinent.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/6/24 at 12:44 PM, Registered Nurse Manager #1 stated the nurses should print the bowel movement report daily which included residents who did not have a bowel movement in the previous three days or nine shifts based on what staff documented. Registered Nurse Manager #1 stated Resident #2 was independent with toileting and that the toilet could be turned off, so staff could keep track of bowel movements. Resident #2's last documented bowel movement was on 4/30/24. Registered Nurse Manager #1 stated they would have expected the floor nurse or the supervisor to have added Resident #2 to the bowel movement list (residents who had not had a bowel movement for than nine shifts and would need the bowel protocol initiated and/or medical notified).</p> <p>During an interview on 5/8/24 at 10:01 AM, Licensed Practical Nurse #1 stated they were supposed to run the bowel movement report in the morning but that they did not run it that day. Licensed Practical Nurse #1 stated that it could have been a lack of documentation from the Certified Nursing Assistants or that Resident #2 may have had bowel movements that staff had not been aware of.</p> <p>During an interview on 5/8/24 at 10:27 AM, the Director of Nursing stated the bowel report should be reviewed every shift by the floor nurse or supervisor, and any resident who had no bowel movement in more than six shifts should be started on the bowel protocol.</p> <p>10 NYCRR 415.12</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641</p> <p>Based on interviews, and record review conducted during the Recertification Survey and complaint investigation (#NY00327781), it was determined that for one (Resident #271) of six residents reviewed for unnecessary medications, the facility did not ensure that the resident was free from significant medication errors. Specifically, Resident #271 received an incorrect dose of a medication for Parkinson's disease for an extended period of time, in a dose that exceeded the recommended maximum daily dose and not as recommended by the specialist. This is evidenced by the following:</p> <p>The facility policy and procedure, Internal and External Consults and Clinics, revised 7/25/22, included that any orders, reports, or notes received from an outside clinician upon return of the resident are given to nursing for review. The nursing team will read the note/recommendations and/or email the note/reconditions to the provider for review. The orders, notes, and reports are scanned into the medical record after being dated and signed off by the medical provider.</p> <p>The facility policy and procedure, Medical Provider Telephone Orders, revised 6/3/22, included that telephone orders may be given by a medical provider to a nurse, pharmacist or occupational therapist, physical therapist, or speech therapist. The order is read back to the medical provider who initiated it along with the elder/patient name, medical record number, location, and room number. The order must be electronically signed by the person accepting the order.</p> <p>Resident #271 had diagnoses including Parkinson's disease, hallucinations and delusional disorder, and a history of frequent falls. The Minimum Data Set Resident assessment dated [DATE] revealed that the resident had severely impaired cognition.</p> <p>An Offsite Appointment Referral for Resident #271, dated 10/2/23 and signed by the neurologist, directed to see the After Visit Summary. The After Visit Summary, dated 10/2/23 included recommendations to stop pramipexole 1.5 milligrams three times a day and to start pramipexole extended relief tablet 3 milligrams once daily for Parkinson's disease with dyskinesia (involuntary movements).</p> <p>Review of Resident #271's electronic health record revealed a telephone order from Physician Assistant #1 to Senior Licensed Practical Nurse #1 dated 10/2/23 for pramipexole 1.5 milligrams, 2 tablets (3 milligrams) three times daily (a total of 9 milligrams daily) starting 10/2/23. The electronic telephone order was not signed until 11/14/23 by Physician #1.</p> <p>Review of Resident #271's Treatment Administration Records revealed that the resident received 3 milligrams of pramipexole three times a day (for a total of 9 milligrams daily vs 3 milligrams daily as recommended) for 30 days in October 2023 and for 6 days in November 2023.</p> <p>In a Clinical Note Report- Medication Review dated 10/12/23, Pharmacy Consultant #1 documented a medication review had been completed. No irregularities or recommendations were identified in the review.</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>In a Medication Incident Report dated 11/7/23 and a Facility investigation dated 11/8/23, the Director of Nursing documented that Physician #1, during a preparation for a regulatory visit, identified that the pramipexole order was entered into Resident #271 electronic health record incorrectly as 3 milligrams three times a day instead one time a day. The report included that the telephone order had been signed off by Physician Assistant #1 on 10/3/24. The Summary of Findings included that Senior Licensed Practical Nurse #1 called the Physician's Assistant about the order change after the resident's appointment with the specialist, took the verbal order regarding the medication change and entered it incorrectly. The Medication Incident Report summary included that the order had not been read back to the Physician Assistant #1 at the time of inputting the order into the electronic health record system.</p> <p>In a 30/60 Day Regulatory Visit Note, dated 11/8/23, Physician #1 documented that Resident #271 was seen by neurology in October and that the Neurologist wanted a reduction in the pramipexole. Physician #1 documented the dose was not decreased but mistakenly increased. During the visit, Resident #271 had said that they felt that they had been hallucinating more and that the hallucinations were worse in the past month. The note included that the resident had a fall the previous day resulting in a head laceration.</p> <p>When interviewed on 5/6/24 at 11:54 AM, the Director of Nursing (with Senior Licensed Practical Nurse #1 present) stated that the error occurred on 10/2/23 when the resident was seen by an off-site neurologist who recommended a medication dosage change. The Director of Nursing stated the Senior Licensed Practical Nurse #1 called Physician Assistant #1 and received a telephone order. Senior Licensed Practical Nurse #1 then transcribed the medication order incorrectly for more medication instead of less. After reviewing the electronic order, the Director of Nursing stated that the order had not been signed until 11/14/23 when Physician #1 electronically signed it. The Director of Nursing stated that they (facility) had a meeting to determine the root cause analysis of the error and it was determined that it was human error.</p> <p>During an interview on 5/6/24 at 12:17 PM, Senior Licensed Practical Nurse #1 stated that they reviewed what the recommended dose change was on the neurology consult form with Physician's Assistant #1 during a telephone call but then transcribed a different dose. After review of the telephone order Senior Licensed Practical Nurse #1 stated the electronic order appeared not to have been signed off until 11/14/23 by Physician #1 (and not by Physician Assistant #1).</p> <p>On 5/7/24 at 10:28 AM Pharmacist #1 stated that the electronic health record system does provide an alert if an order exceeds the recommended dose. Pharmacist #1 stated that the alert would have occurred during the original filling of the medication. Pharmacist #1 stated that the order came in towards the end of the day and may have been missed due to alert fatigue on the pharmacist's part. Pharmacist #1 stated that they had completed the Medication Review on 10/12/23 and had missed that the pramipexole had been ordered at a dose that exceeded the recommended daily dose.</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>When interviewed via telephone on 5/7/24 at 10:34 AM, Physician's Assistant #1 stated that the Senior Licensed Practical Nurse #1 had called them when they got the note back from the neurology consult and read the recommendations to them. Physician Assistant#1 approved the recommendation and Senior Licensed Practical Nurse #1 input the order into the electronic health record. The order should then go to their inbox to be signed. Physician's Assistant #1 recalled that they had approved the recommendation for the change but could not recall if they had signed the telephone order for it but if they had signed the electronic telephone order, their name and the date signed would be on the order. Physician's Assistant #1 stated that the process now requires the full consult note before approving and signing an order. Physician's Assistant #1 stated that the side effects from higher doses of pramipexole could include nervousness, restlessness, weight loss, and worsening Parkinson's symptoms but could not say that they saw anything acutely different with Resident #271 due to the increased dosage.</p> <p>Based on the following corrective actions, it was determined that the facility implemented a plan of care to correct the non-compliance effective 11/22/23 and no further plan of correction is required:</p> <ul style="list-style-type: none"> - A Medication Incident Report and investigation was started on 11/7/23. - An education referral was provided to Senior Licensed Practical Nurse #1 on 11/7/23. - On 11/7/23 the order for pramipexole 1.5 milligrams, 2 tablets (3 milligrams) three times daily was discontinued. Pramipexole extended relief 3 milligrams one time daily was ordered on 11/7/23 to begin on 11/13/23. - Resident #271 was assessed by medical team on 11/7/23 and 11/8/23. - The facility policy and procedure, Internal and External Consults and Clinics, was reviewed on 11/8/23. - The medication error was reported to The New York State Department of Health on 11/9/23. - Education was provided to all nursing staff responsible for taking orders from medical team. - The medical team was provided with education regarding having nurses read back orders and/or scan/email orders to provider prior to entering orders into the electronic health record. <p>10 NYCRR 415.12(m)(2)</p>		

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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>49686</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey, the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Laws for one (third-floor resident unit) of two medication rooms reviewed. Specifically, numerous controlled medications (drugs that are regulated by law due to their potential for abuse or addiction), including narcotics and opioids were observed unsecured and not in a double locked cabinet per the regulations. This is evidenced by the following.</p> <p>The facility policy Medications-Storage, Distributions, Administration and Wasting of Controlled Substances, dated 4/11/22 documented that controlled substances must be stored, distributed, and administered in a safe, secure manner with total compliance with all legal and regulatory requirements. The narcotics supply is to be kept under two locks at all times, and all controlled substances are to be returned to the medication room narcotic cabinet and double-locked after a medication pass.</p> <p>During an observation and interviews on 5/7/24 at 8:48 AM of the third-floor medication room with Registered Nurse Manager #1, the narcotic (controlled medications) cabinet double doors were open and unlocked, leaving the controlled narcotic medications unsecured. Registered Nurse Manager #1 stated the controlled medication cabinet doors should not be unlocked. Licensed Practical Nurse #1 returned to the third-floor medication room at this time and stated they had left the narcotic cabinet unlocked because they were in a hurry. The cabinet contained numerous bags of controlled substances including pain medications, narcotics, opioids and anti-anxiety medications.</p> <p>In an interview on 5/8/24 at 10:01 AM, Licensed Practical Nurse #1 stated that the narcotic medication cabinet doors should not be left unlocked and that the doors should only be unlocked when counting the medications with another nurse or when receiving a pharmacy delivery.</p> <p>In an interview on 5/8/24 at 10:30 AM, the Director of Nursing stated that the controlled medication cabinet doors should always be kept locked.</p> <p>10 NYCRR 415.18(e)(1-4)</p>		