

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews (iQIES #2730965), the facility failed to ensure a safe, clean, comfortable, and homelike environment for one of five units (Maple unit) reviewed. Specifically, the Maple Unit dining room ceiling leaked. Findings include: The facility policy Maintenance and Repairs, last reviewed 05/15/2025, documented the facility ensured all units were free of all hazards and maintained in good repair. Regular audits of the building were conducted and assured the building was in optimal condition and supported a safe and well-maintained environment. The following observations were made of the Maple unit dining room: -On 06/22/2026 at 12:17 PM, there was a ceiling tile above a table that seated eight residents and 75% of the tile was stained brown. At 4:18 PM, it was raining outside, and the stained ceiling tile was dripping. There was no receptacle to collect the drainage and no wet floor sign. There was an approximately 2 feet by 2 feet puddle on the floor. There was one resident watching television in the dining room. -On 06/23/2026 at 8:29 AM, the stained ceiling tile bowed out from the ceiling approximately 3 inches. Residents were eating breakfast at the table under the ceiling tile. -On 06/25/2026 at 1:30 PM, the stained ceiling tile bowed out from the ceiling approximately 3 inches. Residents were playing bingo at the table under the ceiling tile. During an interview on 06/26/2026 at 11:08 AM, Certified Nurse Aide #38 stated the dining room ceiling leaked sometimes when it rained. When that happened, they had to move the table under the leak and maintenance took the tile out and placed a big garbage can under it. It was a while since they had seen the ceiling leak. The residents complained about the leaks if they were during an activity or a meal. Ceiling leaks were not homelike. During an interview on 06/26/2026 at 11:30 AM, the Director of Plant Operations stated there was a leak in the Maple unit dining room after the spring thaw. The roof was old. They were not informed of a leak this week. They observed the stained ceiling tile in the dining room and stated it was the same area that previously leaked and there was a lot of ductwork and vents in that area of the roof. It was not homelike to have a leaking ceiling in the dining room. 10 New York Codes, Rules, and Regulations 415.29(i)(1)		

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

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	
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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interviews, the facility failed to ensure residents were free from abuse and neglect for one of one resident (Resident #167) reviewed. Specifically, Resident #167 required assistance of two for transfers using a mechanical lift and on 05/19/2025, Certified Nurse Aide #21 used a stand pivot transfer without assistance resulting in a fractured right arm. This resulted in actual harm to Resident #167 that was not Immediate Jeopardy. Findings include: The facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, last reviewed 01/15/2024, documented that each resident would be free from abuse or neglect and would not be tolerated. The facility policy Interdisciplinary Care Plans, last reviewed 04/20/2026, documented the facility would develop and implement individualized care plans for each resident to meet the resident's needs. The facility policy Assistive Devices and Equipment, last reviewed 04/26/2026, documented staff were to be trained and use care planned devices for resident mobility and safety. Resident #167 had diagnoses of arthritis, osteoporosis (weak bones), and dementia. The 04/10/2025 Minimum Data Set (a resident assessment tool) documented the resident had severe cognitive impairment, limited range of motion in both arms and one leg and was dependent on transfers. The 12/26/2024 revised Comprehensive Care Plan documented the resident had self-care deficits, was resistive to care, was non-ambulatory, was at risk for pain due to osteoporosis, and was a fall risk. Interventions included Hoyer (mechanical) lift with a wedge between the legs for transfers and give clear explanation of care activities prior to performing. The 05/19/2026 resident care instructions documented the resident was non-ambulatory and transferred with assistance of two using a Hoyer lift. The 05/19/2025 at 10:50 AM, Registered Nurse #52 progress note documented they were notified by the Nurse Manager the resident was complaining of right arm pain while in the shower room. The resident was assessed and was yelling out in pain when their right arm was touched. An order for an x-ray of the right shoulder and arm was ordered, and the resident was provided with one dose of Roxanol (morphine) 1 milligram. The 05/19/2025 at 11:18 AM x-ray report documented the resident had an age-indeterminate fracture of the right arm correlating with timing of trauma and pain. The 05/19/2025 at 1:05 PM Registered Nurse Unit Manager #14 progress note documented the resident was screaming in pain and stated their arm hurt. An x-ray was completed with abnormal findings. The resident was sent to the hospital for further evaluation at 12:16 PM. Incident Summaries with Witness Statements: -The 05/19/2025 Certified Nurse Aide #22 witness statement documented they asked Certified Nurse Aide #21 for assistance transferring Resident #167 and went to get a Hoyer sheet to transfer the resident. They saw Certified Nurse Aide #21 stand the resident by themselves and pivoted the resident into the shower chair. Immediately after the resident was in the chair, the resident yelled out in pain. Certified Nurse Aide #21 stated they thought the resident's arm broke. The supervisor was notified at that time. -The undated Certified Nurse Aide #21 witness statement documented they were transferring Resident #167 into a shower chair using a Hoyer lift, the resident was closer to one side of the chair than the other, the aide did not realize the resident's arm was back, and the aide heard a snap. Registered Nurse Manager #14 was made aware. -The 5/19/2025 Registered Nurse Unit Manager #14 witness statement documented they were in their office, heard Resident #167 yell out in pain, went to assess the situation, and found the resident holding their right arm stating it hurt badly. When the right arm was assessed, the resident started screaming out in pain. Certified Nurse Aides #21 and #22 were interviewed immediately. A nurse practitioner was asked to assess the resident, the aides were told to place the resident in bed, and an x-ray was ordered. Certified Nurse Aide #21 told the manager they were transferring the resident to a shower chair using a Hoyer lift. Certified Nurse Aide #22 was brought into the office, an interview was conducted, and Certified Nurse Aide #22 stated Certified Nurse Aide #21 transferred the resident by themselves using a stand and pivot method. -The 05/20/2025 incident report summary documented (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	
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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assistant Director of Nursing #23 spoke with Certified Nurse Aide #22 at 11:30 AM on 05/19/2025 post incident. Certified Nurse Aide #22 stated they asked Certified Nurse Aide #21 to assist with transferring the resident, went to get a Hoyer sheet, returned to the room, and Certified Nurse Aide #21 told them to put the pad in the chair. Certified Nurse Aide #22 lifted the resident and performed a stand-pivot transfer to place the resident into a shower chair. Upon being seated in the shower chair, Resident #167 began screaming in pain and Certified Nurse Aide #21 stated they thought the resident's arm broke. Certified Nurse Aide #22 asked the other aide if the resident was a Hoyer lift at all times or as needed. Certified Nurse Aide #21 stated at all times. Registered Nurse Unit Manager #14 was notified. Certified Nurse Aide #21 told Certified Nurse Aide #22 the family was made aware and told them to make up a story, so they did not get into trouble. When interviewed by the former Director of Nursing, Certified Nurse Aide #21 told them when the resident was transferred to the chair, they were leaning to the left. When Certified Nurse Aide #21 straightened the resident out, the aide did not notice the resident's right arm was bent behind them and heard it snap. Certified Nurse Aide #21 stated the resident was transferred via Hoyer lift. The incident was reported to the New York State Department of Health on 05/19/2025. After further investigation, it was determined that Certified Nurse Aide #21 did not transfer the resident via Hoyer lift, which was a care plan violation. Certified Nurse Aide #21 was terminated on 05/20/2025 at 02:30 PM for care plan violation resulting in injury. During an interview on 06/26/2026 at 11:23 AM, Registered Nurse Unit Manager #14 stated Resident #167 required a Hoyer lift transfer with assistance of two. On 05/19/2025, Certified Nurse Aides #21 and #22 were working together to perform Resident #167's pre-shower transfer. Registered Nurse Unit Manager #14 stated they heard a resident scream, went to Resident #167's room, saw the Hoyer lift in the room and asked what had happened. The aides stated the resident's arm got stuck in the lift. The nurse went back to their office, and the aides took the resident to the shower room. Certified Nurse Aide #22 later told them Certified Nurse Aide #21 stood the resident and pivoted them to the shower chair, and they heard the resident's arm snap. Certified Nurse Aide #22 stated they did not assist at all with the transfer. Registered Nurse Unit Manager #14 and the Director of Nursing went to talk to Certified Nurse Aide #21 who was crying. The aide was immediately suspended and did not return to work. The resident went to the hospital that day and it was determined the resident sustained an arm fracture. The Director of Nursing completed an incident report, and the outcome was the resident sustained a fractured arm due to a care plan violation. Staff education on following care plans and resident transfers was done shortly after the incident. During an interview on 06/26/2026 at 12:25 PM, Physician #2 stated they remembered the situation although Nurse Practitioner #20 was more familiar with it. They stated if there were no other comorbidities, the care plan violation contributed to the shoulder/arm fracture. During an interview on 06/26/2026 at 12:32 PM, Nurse Practitioner #20 stated the resident broke their shoulder due to the care plan violation when they were transferred via stand and pivot versus the Hoyer lift as planned. The resident had osteoporosis and was at significantly high risk for fractures. The resident sustained a broken shoulder because of the care plan violation. During a telephone interview on 06/26/2026 at 12:37 PM, Assistant Director of Nursing #23 stated they were the Director of Nursing at the time of the incident. Staff should follow each resident's care plan to prevent adverse situations. They were made aware of the incident immediately. Certified Nurse Aide #22 was assigned to the resident, asked Certified Nurse Aide #21 to assist with transferring the resident via mechanical lift, left the room to get the lift and Certified Nurse Aide #21 independently transferred the resident using a stand and pivot method before Certified Nurse Aide #22 returned to the room. Certified Nurse Aide #21 was immediately suspended, terminated shortly after that, an investigation was done timely, and the resident sustained an arm fracture due to the care plan violation. The facility provided transfer and care plan education for all nursing staff shortly after the incident. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)		