

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/01/2024
NAME OF PROVIDER OR SUPPLIER  Samaritan Keep Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  133 Pratt St Watertown, NY 13601	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37385</p> <p>Based on record review and interviews during the abbreviated surveys (NY00308228 and NY00322916) the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported to the New York State Department of Health as required. Specifically, Resident #2 sustained a fracture from a transfer with a mechanical lift and Resident #3 eloped (exited, undetected by staff) to a non-resident area and the incidents were not reported as required.</p> <p>Findings include:</p> <p>The Accident and Incident Investigating and Reporting policy revised 10/18/2022 documented:</p> <ul style="list-style-type: none"> <li>- any alleged violation of abuse, mistreatment, neglect, injuries of unknown origin, or misappropriation of resident's property will be reported to the New York State Department of Health if and when the reasonable cause threshold has been achieved.</li> <li>- The policy references included the 2016 New York State Department of Health Nursing Home Incident Reporting Manual.</li> </ul> <p>The New York State Department of Health Nursing Home Incident Reporting Manual dated 8/2016 documented the following incidents are reportable: a resident in a non-resident area, if the resident was found in a potentially hazardous non-resident area and an incident or accident related to entrapment or use of equipment.</p> <p>1) Resident #2 had diagnoses including anemia, anxiety disorder, and difficulty walking. The 8/1/2023 Minimum Data Set assessment documented the resident had intact cognitive function and no falls since the last assessment.</p> <p>The 8/22/2023 physical therapist #15's note documented the resident had shown improvement with mobility. Care plan recommendations included transfer with the sit-to-stand mechanical lift with assistance of 2 staff.</p> <p>The 8/28/2023 facility investigation summary signed by the former Administrator and former Director of Nursing documented:</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: 335431
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 8/27/2023 at approximately 6:45 PM, certified nurse aides #3 and 6 were transferring Resident #2 utilizing the sit-to-stand lift per their care plan. According to staff interviews, the legs to the sit-to-stand became jammed under the wheelchair they were transferring Resident #2 from. While certified nurse aides #3 and 6 were getting the sit-to-stand machine released from under the wheelchair chair, the resident became anxious and removed their hands from the machine causing them to slide down with the sling still in place. This caused the resident to be in a standing position pushing their shoulders upward. Certified nurse aides #3 and 6 lowered the resident to the floor and notified registered nurse Supervisor #2.</p> <p>- Registered nurse Supervisor #2 completed an assessment on Resident #2 and Resident #2 had complaints of left shoulder pain which resolved approximately 30 minutes later with no apparent injuries.</p> <p>- Resident #2 had complaints of pain again to the left shoulder later in the shift. The physician was notified and an order for an x-ray was obtained. A left clavicle fracture was identified.</p> <p>- It was concluded there was no evidence of abuse, neglect or mistreatment. The facility determined the facts did not meet reasonable cause threshold for reporting as defined by the New York State Department of Health regulations. Resident #2 was lowered to the floor by the certified nurse aides with no care plan violations identified.</p> <p>The radiology report dated 8/28/2023 documented the indication for radiography of the left shoulder was a recent fall and the impression was oblique fracture of the left clavicle.</p> <p>There was no documented evidence the facility reported the resident sustained a fracture related to use of equipment to the New York State Department of Health.</p> <p>During an interview with licensed practical nurse #1 on 3/20/2024 at 11:30 AM, they stated on 8/27/2023, Resident #2 was calling out. The nurse arrived and saw the resident up in the sling on the sit-to-stand lift and the machine was stuck and could not be moved. The only option was to lower the resident to the floor onto their stomach, as there was no room to turn them. The resident complained of pain in their arm while they were on the floor.</p> <p>During an interview with certified nurse aide #3 on 3/20/2024 at 1:05 PM, they stated when they went to transfer the resident from their wheelchair to bed, the sit-to-stand lift got stuck under the resident's wheelchair when they went to pull it back, the resident began yelling and let go of the machine, causing their feet to be misplaced and unable to be corrected. The resident was lowered to the floor by certified nurse aides #3 and 6 while licensed practical nurse #1 pulled the machine back. The resident had to be lowered face down to the floor, as there was no room to turn the resident or move the sit-to-stand and wheelchair. The resident's wheelchair was positioned next to the head of the bed, with the lift in front of the resident, so that when lifted, the resident would pivot to the bed. The closet and cabinets were on other side of the wheelchair and machine, and there was no room to swing the lift or the resident's wheelchair around.</p> <p>During a telephone interview with certified nurse aide #6 on 3/25/2024 at 1:33 PM, they stated when transferring the resident, the sit-to-stand got stuck under their electric wheelchair, which had a large footrest. The resident moved during the transfer and their feet were not positioned correctly, then they let go of the lift and were hanging in the lift. The aides had to lower the resident to the floor, and the resident was hollering about pain in their shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview with the Director of Nursing on 4/1/2024 at 2:44 PM, they stated they were not in the role of Director of Nursing when Resident #2 sustained the fracture following the incident on 8/27/2023. They stated the facility utilized the New York State Department of Health Nursing Home Incident Reporting Manual to determine if an incident was reportable. The Director of Nursing was not certain if the incident was reportable as they did not complete an investigation. They were unable to state the reason the former Director of Nursing did not report the incident since it involved an injury with equipment use.</p> <p>2) Resident #3 had diagnoses including dementia with other behavioral disturbance, anxiety disorder, and repeated falls. The 11/10/2022 Minimum Data Set assessment documented the resident had severe cognitive impairment and did not exhibit behaviors of wandering.</p> <p>The 11/8/2022 Elopement Evaluation documented the resident had a history of or attempted to leave the facility without informing staff. The resident did not wander, did not express a verbal desire to go home, or did not stay near an exit.</p> <p>The 11/8/2022 at 4:06 PM AM, nursing progress note entered by registered nurse #10 documented the resident had no recent attempts to leave the unit, was attending off unit activities with monitoring, scored 1 (low) on the elopement risk evaluation, and will be trialed off the wander alert device at this time. Door alarms were in place at the exits to the unit during this trial period.</p> <p>The 11/16/2022 at 6:37 AM, nursing progress note entered by licensed practical nurse #9 documented the resident was carrying their catheter bag, looking for a way out of the unit. They would not let staff do their finger stick (blood sugar monitoring) stating they did not have time for that, they were looking for the kids to take them home, they tried a couple of times, then walked up the hall.</p> <p>The comprehensive care plan, updated 11/23/2022, documented the resident was at risk to wander related to dementia with behaviors. Interventions included: identify a pattern of wandering, intervene as appropriate; distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book. There were no documented interventions related to the use of the wander alert device, the trial period of cessation of the device, or any new interventions to address the resident's exit-seeking behavior.</p> <p>The 12/30/2022 at 10:53 PM nursing progress note entered by licensed practical nurse #11 documented the resident got on the service elevator and went to the 8th floor diet kitchen and was returned by staff (the resident resided on the 3rd floor).</p> <p>There was no documented incident report completed when the resident left the unit undetected by staff and accessed a non-resident area on 12/30/2022.</p> <p>There was no documented evidence the facility reported the resident was found in a non-resident area to the New York State Department of Health.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview with licensed practical nurse #14 on 3/25/2024 at 1:07 PM, they stated the resident had behaviors of wandering and trying to find snacks. On 12/30/2022, the resident got onto the service elevator and went to another floor. The service elevator was next to the other elevators on the unit. The difference was the service elevator had a rear door that opened to the kitchens on the units. The only other means to get into the kitchen was entering a code on the door from the hallway. The kitchen and service elevator were not for resident access. The licensed practical nurse could not recall if an incident report was completed as a result of the resident getting into the kitchen on another unit.</p> <p>During a telephone interview with the Director of Nursing on 4/1/2024 at 2:44 PM, they stated they were not in the role of Director of Nursing when Resident #3 left the unit on 12/30/2022. They were unaware of an incident report or of the reason the incident was not reported to the New York State Department of Health. They stated the service elevator and kitchen were not resident areas and based on the New York State Department of Health Nursing Home Incident Reporting Manual, the incident was reportable.</p> <p>10NYCRR415.4 (b) (2)</p>		