STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335431	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Samaritan Keep Nursing Home Inc	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 during the survey (Complaint #756448), the facility failed to ensure residents were free from abuse and neglect for one (1) of three (3) residents (Residents #3) reviewed. Specifically, on 03/24/2024 at approximately 12:00 AM, Resident #3 was zip tied (a fastener with a locking, self-snagging nylon strap used to secure items) to the able riser (enabler bar) on their bed by Licensed Practical Nurse #7, for approximately 45 minutes to one (1) hour. This resulted in Immediate Jeopardy Past Non-Compliance for Resident #3 and placed all residents at risk for abuse. Findings include:The facility policy Prevention of Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property, revised 02/10/2023, documented abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Involuntary seclusion was confinement to his/her room against the resident's will. In addition to orientation, all employees should be in-serviced annually regarding: the appropriate interventions for dealing with aggressive resident behaviors; how to report alleged allegations of abuse, neglect, and misappropriation of resident property; and what constitutes abuse, neglect, and misappropriation of resident property.\Resident #3 had diagnoses including Alzheimer's dementia and Parkinson's (a progressive neurological disorder) disease. The 01/24/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition; did not exhibit behavioral symptoms; and walked independently with supervision. The 01/18/2024 comprehensive care plan documented the resident was an elopement/wandering risk related to disorientation to place, impaired safety awareness, and wandering aimlessly. Interventions included distractions from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book; and identify pattern of wandering. The 01/19/2024 comprehensive care plan documented the resident had a potential psychosocial well-being problem related to their disease process of dementia. Interventions included allowing time to answer questions and to verbalize feelings, perceptions, and fears. The 03/25/2024 facility investigation synopsis completed by the Director of Nursing documented on 03/24/2024 at approximately 12:00 AM, Certified Nurse Aide #4 witnessed Licensed Practical Nurse #7 place a zip tie around Resident #3's right wrist connecting it to the able riser, in the down position, on the resident's bed. Certified Nurse Aide #6 reported they observed Licensed Practical Nurse #7 place a zip tie on Resident #3's right wrist, connecting it to the right side rail which was in the down position. Certified Nurse Aide #6 stated on 03/24/2024, approximately 45 minutes to one (1) hour later, they cut the zip tie off Resident #3's right wrist. Certified Nurse Aide #4 reported the incident to oncoming Licensed Practical Nurse #22 (at 3:00 AM), who reported to Registered Nurse Supervisor #5. Licensed Practical Nurse #22 immediately checked on Resident #3 and noted they did not find any marks on the resident's wrists. Registered Nurse Supervisor #5 immediately assessed Resident #3 who did not sustain any injury as evidenced by no redness, no bruising, and no open areas. During the assessment, there was no evidence of or display of any signs or symptoms of psychological (continued on next page)

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the desk at the nurse's station. Before leaving for the night, they saw Licensed Practical Nurse #7 holding Resident #3's door shut. Resident #3 would turn the handle and Licensed Practical Nurse #7 kept the handle still, not allowing the resident to open the door. Licensed Practical Nurse #7 talked through the door and said [Resident #3], go back to bed. The 03/26/2024 Police Report documented an unlawful restraint possibly used on a resident. It was documented that on 03/24/2024, Resident #3 had a sock placed over their right hand and several plastic zip ties around the hand, restraining the resident to the bed. During an interview on 02/11/2026 at 8:30 AM, the Director of Nursing stated they investigated the incident with Resident #3 on 03/24/2024. All parties were suspended pending investigation.Certified Nurse Aide #6 was terminated for not reporting the incident and Licensed Practical Nurse #7 was terminated due to the found abuse. The incident was reported the same day it was discovered. Based on the investigation, Licensed Practical Nurse #7 was found to have zip tied Resident #3's wrist to the bedrail. They were unsure if it was both wrists or which one. They still had the zip ties from the investigation. The incident occurred on the overnight shift from 3/24/2024 to 3/25/2024. The staff members were suspended on 3/25/2024 in the morning. During a telephone interview on 02/11/2026 at 10:58 AM, Certified Nurse Aide #4 stated there was an incident with Licensed Practical Nurse #7 and Resident #3 on 03/24/2024. Resident #3 had frequent falls from bed, so they had pressure mats that alerted when the resident got out of bed. Licensed Practical Nurse #7 got tired of having to come to the unit and check on the resident, so they stated they were going to give Resident #3 their own personal protective bracelets. They asked Licensed Practical Nurse #7 what that meant and told them it was illegal to restrain the residents. Licensed Practical Nurse #7 and Certified Nurse Aide #6 went into Resident #3's room, they thought they were putting the resident back to bed. They continued their nightly chores of returning clean clothes to the residents' closets. When they went in with Resident #3's clothing they saw the zip ties. Licensed Practical Nurse #7 and Certified Nurse Aide #6 came in right after they left and cut off the ties. Certified Nurse Aide #4 stated they did not have anything to remove the zip ties with at the time. They told the oncoming nurse about the situation. They did not know where the zip ties came from. During a telephone interview on 02/11/2026 at 11:43 AM, Certified Nurse Aide #6 stated Licensed Practical Nurse #7 was not acting normally during that shift on 03/24/2024. They went out for a smoke break, and when they came back their face was red, they were sweating, and just not acting right. Licensed Practical Nurse #7 was getting really upset with Resident #3. The resident kept removing stuff from their closet, leaving their room, up and down moving all night. At the end of the night, Licensed Practical Nurse #7 asked for the scissors they carried. The only time they saw any zip ties was in a package on a cart in the hallway. They were unused in the package from the store. They did not know where they came from. Certified Nurse Aide #6 stated they had no idea about the zip ties and Resident #3 until they came from their shift and was sent to a room on the first floor. They did not know where the ties came from or anything about taking them off. Resident #3 was up a lot that night and Licensed Practical Nurse #7 said they would take care of it. During a telephone interview on 02/12/2026 at 9:39 AM, Licensed Practical Nurse #22 stated they came in for the shift at 2:30 AM on 03/24/2024, and they went to look for Licensed Practical Nurse #7 to get report. Licensed Practical Nurse #7 was acting differently; they were talking fast and very erratic. Licensed Practical Nurse #7 left their shift with Certified Nurse Aide #6. Certified Nurse Aide #4 told Licensed Practical Nurse #22 they had to talk, and told them, Licensed Practical Nurse #7 zip tied Resident #3 to the bed. Licensed Practical Nurse #22 went to Resident #3 and did not see any marks on Resident #3's hands or ankles. They found two (2) zip ties under the bed. Before Certified Nurse Aide #6 left they came to the nurse's station and picked up (continued on next page)

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