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	03/20/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review the facility failed to ensure the interdisciplinary team determined a resident's ability to safely administer their own medications, if clinically appropriate, for one (1) of one (1) resident (Resident #133) reviewed. Specifically, Resident #133 had a medication cup at their bedside containing one white round pill and one half of a round white pill. There was no documented evidence of assessments and/or physician orders for the residents to safely self-administer medications.Findings included:The facility policy Administration of Medication Guidelines, last reviewed 04/02/2025, documented the nurse was personally responsible for every drug they administered. They stayed with the resident until they swallowed the drug, and medications were not left with the resident, except with a doctor's order.The facility policy Self-Administration of Medications, created 02/18/2026, documented residents who desired to self-administer medication would be allowed to do so under guidelines in the policy. Residents were evaluated for desire and competence to self-medicate, and a licensed nurse completed an evaluation on each resident upon admission, a significant change in condition and/or annually. Results of the evaluation were reviewed by the Interdisciplinary Care team for a team decision to determine the resident's ability to self-medicate, and the decision was documented in the Care Plan. Residents who did not meet the guidelines for self-medication administration were administered their medications by the nurse.Resident #133 had diagnoses including neurocognitive disorder (decline in mental function), Parkinson's disease (progressive neurological disorder), and epilepsy (seizure disorder). The 02/05/2026 Minimum Data Set assessment documented the resident was cognitively intact, had no behavioral symptoms, and was independent for most activities of daily living.The 02/06/2026 Comprehensive Care Plan documented the resident took carbidopa - levodopa (medication used to treat Parkinson's disease). Interventions included to administer medications as ordered by the provider; monitor and document side effects and effectiveness every shift; and document and report adverse reactions which included increased risk of low blood pressure on rising, falls, significant confusion, restlessness, delirium, difficulty walking, nausea, dizziness, hallucinations, agitation.During an observation and interview on 03/15/2026 at 4:48 PM Resident #133 was in their room. There was a medication cup at their bedside containing one white round pill and one half of a round white pill. Resident #133 stated the nurse left it there and they were not sure what the medication was, and they should probably take it. The resident was not sure how long it was there.There was no documented evidence of a medical order for self-medication administration or a self-medication administration assessment.During an interview on 03/15/2026 at 4:50 PM Licensed Practical Nurse #7 stated the medication in the cup in Resident #133's room was levodopa, and they thought the resident had taken the medication. They stated they instructed the resident to take the medication, and they did. They signed the medication as administered at 4:43 PM.During a follow-up interview on 03/19/2026 at 11:00 AM Licensed Practical Nurse #7 stated licensed practical nurses were responsible for medications. They occasionally signed off medications prior to administering them. Resident #133 did not have an order for self-medication administration. They stated they were distracted when they gave Resident #133 their medication and left the room before the resident took them. They did not pay attention, and they should have.During an interview on 03/19/2026 at 11:41AM (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Unit Manager #6 stated when nurses passed medication, they expected them to ensure residents swallowed their medications at that time. Medications such as carbidopa - levodopa needed to be taken at a specific time as it was used for seizures. There were no residents on their unit who had orders to self-medicate. They stated medications should not be left at the bedside. 10 New York Codes, Rules, Regulations 415.3(f)(1)(vi)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing and promote wound healing for one (1) of three (3) residents (Resident #281) reviewed. Specifically, Resident #281 was admitted with a Stage 2 (partial thickness skin loss) pressure ulcer and did not have admission orders for wound care.Findings include:The facility policy Wound Care and Pressure Injury Prevention and Treatment, last reviewed 02/11/2026, documented the facility would implement a systemic interdisciplinary process for the prevention, identification, assessment, treatment, and monitoring of wounds and pressure injuries to ensure pressure injuries were prevented and that existing wounds received appropriate and timely treatment. The nurse managers were responsible for performing comprehensive wound and skin assessments, initiating/updating care plans, obtaining and entering provider orders, overseeing wound care practices, participating in wound rounds, and ensuring follow-up on recommendations.Resident #281 had diagnoses including diabetes, muscle weakness, and need for assistance with personal care. The 02/13/2024 admission Minimum Data Set assessment documented the resident had moderate cognitive impairment; was frequently incontinent; required substantial/maximal assistance with personal hygiene and showering/bathing; was dependent with toileting hygiene; did not have unhealed pressure ulcers; and was at risk for pressure ulcers.The 02/08/2024 admission Assessment completed by Registered Nurse Unit Manager #21 documented the resident had redness and a dime size Stage 2 pressure ulcer on their coccyx (tailbone).There was no documented evidence of wound care orders for the coccyx upon admission to the facility.The Comprehensive Care Plan initiated 02/09/2024 and revised 02/21/2024, documented the resident had a potential/actual impairment (Stage 2 pressure injury to coccyx) to skin integrity related to impaired mobility. Interventions included follow facility protocols for treatment of injury, encourage good nutrition and hydration to promote healthier skin, monitor/document size and location of skin injury and report signs and symptoms of infection.The 02/13/2024 Skin Only Evaluation completed by Licensed Practical Nurse #24 documented the resident had a skin issue on their back and coccyx.The 02/13/2024 provider order documented apply foam dressing to the coccyx every day shift every 3 days for protection.The resident did not have wound care orders for 5 days.The 02/16/2024 Registered Nurse Unit Manager #21 progress note documented the resident had a very small Stage 2 pressure ulcer on their coccyx upon admission. Wound care orders were put in place for protection, and the wound healed.The resident was hospitalized from [DATE]-[DATE].The 02/21/2024 admission Assessment completed by Registered Nurse Unit Manager #21 documented the resident had a reopened Stage 2 pressure ulcer on their coccyx.The 02/21/2024 at 12:57 PM physician orders documented resume previous orders. The provider order documented apply foam dressing to the coccyx every day shift every three (3) days for protection was discontinued 02/23/2026.The 02/23/2024 Registered Nurse Unit Manager #21 progress note documented they completed wound rounds with the wound care nurse and the resident's skin was clear at that time.The 02/27/2024 Skin Only Evaluation completed by Licensed Practical Nurse #20 documented the resident had a pressure ulcer on their coccyx.The 03/04/2024 Licensed Practical Nurse #24 progress note documented the resident's family called and complained the resident had an open area on their buttocks. The nurse manager was aware and assessed the resident.There was no documented evidence that the Skin Only Evaluation was completed on 03/05/2026.The 03/05/2024 Licensed Practical Nurse #36 progress note documented the resident refused to be repositioned on their side for an open area on their right buttock.The 03/08/2024 Registered Nurse Unit Manager #21 progress note documented they assessed the resident's coccyx with the wound care nurse. The area was red and had no open areas. The 03/10/2024 provider order documented the following wound care orders. Stage 2 pressure ulcer to the coccyx cleanse with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	normal saline, pat dry, apply skin prep to the surrounding skin, and cover with foam dressing on the day shift every three (3) days and as needed.The resident did not have wound care orders for the Stage 2 pressure ulcer on their coccyx for 12 days from 02/27/2024-03/10/2024.During an interview on 03/19/2026 at 11:24 AM, Registered Nurse Unit Manager #21 stated when a resident was admitted to the facility they reviewed the hospital paperwork, completed a head-to-toe assessment which included a skin/wound assessment, emailed the wound team so any wounds would be tracked, and notified medical to obtain orders. Resident #281 was admitted on [DATE] with redness and a Stage 2 pressure ulcer on their coccyx. They stated they sent an email to the wound team on 02/08/2026 so they were unsure why the resident was not seen by the team, and they could not recall why there were no wound care orders until 02/13/2024. The resident was readmitted from the hospital on [DATE] with a Stage 2 pressure ulcer on their coccyx. Licensed practical nurses were responsible for completing weekly skin checks. The 02/27/2024 skin check documented a Stage 2 pressure ulcer, so they were unsure why there was no documented registered nurse assessment, wound provider notes, or orders for wound care until 03/10/2024. They stated it was a long time ago and they could not recall why Resident #281's skin and wounds were not monitored appropriately.During an interview on 03/19/2026 at 12:14 PM, Licensed Practical Nurse #20 stated they were responsible for completing weekly skin checks on residents and if they found any issues they notified the registered nurse. They completed the 02/27/2024 skin check on Resident #281 and it appeared the wound was not resolved. They could not recall but thought they may have notified Registered Nurse #21.During an interview on 03/19/2026 at 12:36 PM, Licensed Practical Nurse/Wound Nurse #26 stated they did not see any wound notes or other documentation for Resident #218. If the wound team was notified the resident had a wound, they entered the information into the system for wound tracking. Resident #281's Stage 2 pressure ulcer should not have gone without an ordered treatment for any amount of time and should have been monitored regularly for progression of healing.During an interview on 03/19/2026 at 1:40 PM, the Director of Nursing stated when a resident was admitted the registered nurse was responsible for completing a clinical evaluation for any skin issues. If the resident had a Stage 2 pressure ulcer on admission the provider should have been contacted to obtain orders for a treatment and the wound team notified so they could complete weekly wound rounds to ensure the treatment was effective. Resident #281 should have had a treatment in place for the Stage 2 pressure ulcer as soon as it was identified. 10 New York Codes, Rules and Regulations 415.12(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews, the facility failed to ensure adequate supervision to prevent accidents for one (1) of one (1) resident (Resident #215) reviewed. Specifically, Resident #215's elopement safety interventions of 30 and 60-minute safety checks and wander guard tag checks were not completed as planned/ordered. Findings include:The facility policy Elopement Prevention, revised 01/11/2023, documented the assigned nurse would check the resident every shift to ensure the wander guard tag was in place and had a blinking red light indicating it was functioning properly. The facility policy Elopement - Resident Evaluation for Potential, revised 02/16/2024, documented elopement precautions would be addressed on the care plan, implementing measures as indicated.The facility policy Increased Supervision-Visual Monitoring Checks and 1 to 1, revised 10/11/2021, documented a resident on increased supervision would have a staff person assigned to do a visual check on the resident within consecutive 30 or 60-minute intervals as necessary; interventions would be added to the appropriate care plan; and the assigned staff person was responsible for observing the resident at designated intervals and documenting the observation on the sheet.Resident #215 had diagnoses including dementia. The 07/18/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition; walked up to 150 feet with a walker independently; and used an elopement alarm daily.The 05/24/2024 Comprehensive Care Plan documented the resident was at risk for elopement due to cognitive impairment. Interventions included check placement and function of wander guard every shift.07/24/2024 incident:The 05/24/2024 elopement risk assessment documented the resident was at high risk for elopement.The 06/27/2024 Licensed Practical Nurse #34's progress note documented the resident was started on a trial of 30-minute checks.There was no documented evidence the resident's Comprehensive Care Plan included initiation of 30-minute checks. The undated Summary of Investigation documented on 07/24/2024 at 5:00 AM the resident was found in the basement lobby by an environmental services employee who responded to the sound of the wander guard system's audible alarm. The resident was last seen at 2:00 AM lying in their bed.The 07/24/2024 Observation Record Safety Check form documented 30-minute checks were not documented as being completed from 12:00 AM through 2:30 PM.During an interview on 03/18/2026 at 11:09 AM and 03/19/2026 at 1:18 PM, Registered Nurse Unit Manager #21 stated once a decision to initiate 30 or 60-minutes checks was made, they communicated it to the nurse and the aide assigned to the resident; the care plan and resident care instructions was updated; and safety check sheets initiated and placed either on a clipboard or in a binder and kept in the zone of which the resident's room was located. They were aware Resident #215 was placed on 30-minute checks in June 2024. Those checks should have been on their care plan and resident care instructions, and they were not sure why they were not. On 07/24/2024, when the resident was found in the basement, they were on 30-minute checks. They stated they were unsure when the last check was documented prior to the resident being found in the basement but it should have been between 4:00 AM and 5:00 AM.During an interview on 03/18/2026 at 12:09 PM and 03/19/2026 at 4:00 PM, the Director of Nursing stated if a resident was put on 30 or 60-minute checks it should be added to the care plan and the resident care instructions. The staff member assigned to that resident was responsible for making sure those checks were documented. On 07/24/2024, Resident #215 had a wander guard and was on 60-minute safety checks. They were provided care at 2:00 AM and went back to sleep. At approximately 4:56 AM the wander guard system in the basement alarmed and an environmental service worker found Resident #215 just outside the basement elevator. The safety check sheet was blank until 3:00 PM on 07/24/2024 but should not have been. They were unsure why they had not caught that when they investigated the incident. March 2026:The 05/24/2024 Comprehensive Care Plan, revised 10/27/2025, documented the resident was at risk for elopement due to cognitive impairment. Interventions included check placement and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function of wander guard on right ankle every shift and continue 60-minute checks.The 01/23/2026 elopement risk assessments documented the resident was at high risk for elopement.The 08/05/2025 physician order documented to check placement and function of the resident's wander alert device every shift.The March 2026 daily Observation Record Safety Check forms documented 60-minute checks were not signed hourly on the following dates: 03/01/2026- 03/03/2026, 03/06/2026, 03/09/2026, 03/12/2026, 03/13/2026, 03/16/2026, and 03/19/2026. The March 2026 Medication Administration Record documented Licensed Practical Nurse #20 signed for checking the placement and function of the resident's wander guard on 03/17/2026 during the day shift.During an interview on 03/17/2026 at 3:20 PM, Licensed Practical Nurse #20 stated wander guard placement and the presence of a blinking red light, indicating the device was functioning properly, was checked daily. They signed they performed all the resident wander guard checks on 03/17/2026, including Resident #215's, but they did not as they were spread too thin that day. Instead, they relied on the aides to tell them if a wander guard was missing or not flashing. Resident #215 eloped in the past and had a history of removing their wander guard. They should have checked the resident's wander guard. They should have asked their manager to help with the checks, but it did not occur to them to do so. During an interview on 03/19/2026 at 11:33 AM, Certified Nurse Aide #35 stated 30-minute checks were listed on the white board at the nurses' station and thought it would be on the resident care instructions but was not sure. The checks entailed documenting what the resident was doing and the initials of the person performing the check. There should not be any blanks on them, and it was the responsibility of the assigned aide to make sure there were not. Resident #215 was on 60-minute checks. They should have safety check sheets kept in a binder and there should not be any blanks on them. During an interview on 03/19/2026 at 11:54 AM, Licensed Practical Nurse #24 stated safety checks were typically communicated verbally during shift report. It should also be on the care plan and resident care instructions. The aide assigned to that resident was responsible for making sure they were completed. There was no follow-up process in place to monitor the completion of the forms. Resident #215 was high risk for elopement and was on safety checks for elopement. During an interview on 03/18/2026 at 11:09 AM and 03/19/2026 at 1:18 PM, Registered Nurse Unit Manager #21 stated wander guards were checked every shift for a blinking red light which meant it was working properly. That check was documented on the treatment administration record and if the nurses were signing for it, they expected it to be done. If a nurse was too busy to complete, they should report so someone else could be assigned. The safety check sheets were completed by the certified nurse aide assigned to the resident and should not have any blanks. No one monitored the sheets to make sure they were complete. It would be good practice for someone to monitor them, but they had not done so because staff should know what they were supposed to do.During an interview on 03/18/2026 at 12:09 PM and 03/19/2026 at 4:00 PM, the Director of Nursing stated nurses should check placement and function of the wander guards every shift and should not be signing they had done so if they had not. The nurse managers should make sure there were no blanks on the safety check sheets. They did not know why there were blanks on them as they thought the nurse managers were checking them and following up if there was a problem. 10 New York Codes, Rules and Regulations 415.12(h)(1)(2)