| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335431 | A. Building<br>B. Wing | 03/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Samaritan Keep Nursing Home Inc | 133 Pratt St<br>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) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observations, record review, and interviews, the facility failed to ensure residents had the right to a dignified existence for two (2) of two (2) residents (Residents #184 and #257) reviewed. Specifically, Residents #184 and #257 had their side rails removed and there was no documented evidence they were provided with education, a therapy evaluation, side rail alternatives, or an opportunity to discuss their concerns prior to the side rails being removed. This resulted in a decline in bed mobility for Residents #184 and #257. Findings include:The facility policy Bed Rail Use - Side Rails, Assist Rails, Transfer Rails, Bed Enablers, revised 09/03/2025, documented assignment of a bed rail would be considered only after all non-bed rail alternatives are attempted; side rails may only be considered to treat a resident's medical symptoms or as an assistive device to assist with mobility and transfer of residents; the resident/representative will be provided education on the risks versus the benefits of using the device so that the resident/resident representative can make an informed decision. The facility policy Resident Rights, last reviewed 09/12/2025, documented residents had the right to participate in their person-centered care planning and treatment; to reasonable accommodation of needs so long as it did not endanger the health or safety of them or other residents; and to a safe, clean, comfortable and home-like environment that allowed them to be as independent as possible. The facility policy Standard of Care - Activities of Daily Living, revised 01/01/2019, documented each resident would receive and the facility must provide the necessary care and services to attain or maintain the highest possible level of functioning and wellbeing as limited by the individual's recognized pathology and normal aging process; residents would be encouraged to perform bed mobility tasks to the extent they were safely able, in alignment with the care plan; and staff would provide appropriate assistance, including use of adaptive equipment, to prevent avoidable decline and promote maximum functional independence. A 09/03/2025 facility issued letter to families and residents documented all use of bed rails was to be discontinued and staff were trained in alternative safety measures. Additionally, a phone number was provided should anyone have questions or would like to discuss further. 1) Resident #257 had diagnoses including morbid obesity and left side paralysis following a stroke. The 02/26/2026 Minimum Data Set assessment documented the resident had intact cognition; was dependent for rolling left and right and returning to lying on their back in bed; and did not use side rails. The 11/14/2023 Comprehensive Care Plan, revised 09/04/2025, documented the resident required assistance with self-care and mobility related to left side paralysis. Interventions included substantial assistance of two (2) for bed mobility. Prior to the 09/04/2025 revision, the resident required substantial/maximal assistance of one (1) for bed mobility. Bed Rail Evaluations documented the following:-On 03/26/2025 the resident displayed poor bed mobility and bilateral side rails were recommended as an enabler to promote independence.-On 09/04/2025 the resident displayed poor bed mobility and bilateral side rails were not indicated. There was no documented evidence that the resident was informed, educated, offered an alternative, or given the opportunity to voice their concerns prior to their side rails being removed. During an interview on 03/17/2026 at 10:04 AM and 03/19/2026 at 10:02 AM, Resident #257 stated they were upset over the removal of their side rails. They previously had two (2) side rails that helped<br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | them reposition themself. No one explained ahead of time the side rails were going to be removed or why. The left side rail allowed them to independently reposition themself, shift their weight, and turn to their left. They stated without that rail they could not move at all. A trapeze was trialed after the rails were removed but it did not help them to roll so they asked that it be removed. During an interview on 03/18/2026 at 1:42 PM, Certified Nurse Aide #23 stated all side rails were taken off last year by administration. They did not recall any discussions or education with the residents prior to their removal. A lot of residents were still unhappy about it. Resident #257 grabbed the side rail with their good hand to help roll themself. At that time, they could document their assistance level as substantial but now, because the resident could no longer help pull themself over, they had to document the resident was dependent. During an interview on 03/19/2026 at 11:23 AM, Certified Nurse Aide #35 stated Resident #257 would grab the side rail to their left to pull and hold themself on their left side. They required minimal assistance to roll to their left when they had the side rail. Now, they had to grab the corner of the headboard to pull themselves over. When they had the trapeze, it did not help them to roll so it was removed. During an interview on 03/19/2026 at 10:52 AM, Licensed Practical Nurse #24 stated in September 2025 maintenance removed all side rails. There were a lot of independent residents that needed something to grab, and their side rails were taken away. Residents and families were very angry, and some were still complaining. Staff were told an alternative to the rails was being worked on and to hold off on therapy evaluations unless there was a decline in function. Resident #257 was able to roll themself to their left with use of the left side rail and minimal assistance of one (1). Without the side rail they now required assistance of two (2) for rolling. The resident had a trapeze, but they did not like it because it was awkward, and it did not help them roll and the resident asked for it to be removed. 2) Resident #184 had diagnoses including right side paralysis and muscle weakness. The 01/22/2026 Minimum Data Set assessment documented the resident had intact cognition; functional impairment on one side of both upper and lower extremities; and required maximum assistance with bed mobility. The 11/14/2023 Comprehensive Care Plan, revised 09/25/2025, documented the resident required assistance with self-care and mobility related tasks. Interventions included substantial/maximal assistance of one (1) for bed mobility. The Bed Rail Evaluations documented the following:-On 08/07/2025 the resident displayed poor bed mobility and bilateral side rails were recommended as an enabler to promote independence.-On 09/04/2025 the resident displayed poor bed mobility and side rails were not indicated. There was no documented evidence the resident was informed, educated, offered an alternative, or given the opportunity to voice their concerns prior to their side rails being removed. The August 2025 certified nurse aide Follow Up Question Report documented the resident required partial assist for rolling left and right in bed most of the time. The certified nurse aide Follow Up Question Report from 09/04/2025-09/30/2025 documented the resident required either substantial assistance or was dependent on rolling left and right in bed most of the time. The certified nurse aide Follow Up Question Report from 03/01/2026-03/19/2026 documented the resident required either substantial assistance or was dependent for rolling left and right in bed most of the time. During an interview on 03/18/2026 at 2:17 PM, Resident #184 stated two (2) maintenance workers removed both of their side rails. No one explained why they were removed, and no alternatives were offered. They used the rail to their right to roll and the one to their left for stability and security when sitting at the edge of the bed. Since the side rail removal, they did not move around in bed as well. They were able to roll to the right by themself but could no longer do so. They talked to Registered Nurse Unit Manager #21, and anyone else who would listen, and was told they were not getting the side rails back. During an interview on 03/19/2026 at 11:23 AM, Certified Nurse Aide #35 stated Resident #184 used the side rails to roll onto their side and to steady themselves when sitting on the edge of the bed. Without the side rails they no longer could pull and hold themself onto their side and when sitting on the bed edge they had to grab at the bed and staff to steady themself. The resident told them they felt like they were losing their independence. The resident previously required assistance of one (1) for bed<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | mobility when they had side rails and now, without the side rails, they required assistance of two (2). During an interview on 03/19/2026 10:52 AM, Licensed Practical Nurse #24 stated Resident #184 was upset over the removal of their side rails because they wanted to be independent but now had nothing to grab. When they had the side rail the resident was able to use the rail effectively with their good hand to pull themself over. During an interview on 03/19/2026 at 1:26 PM, Registered Nurse Unit Manager #21 stated in September 2025 Administration decided the facility would be side rail free and removed all side rails. They thought a letter was sent out regarding the removal. They were not involved in any discussions or education with the residents prior to taking the side rails off. There were no therapy evaluations or alternative options offered prior to the removal and some residents expressed disagreement with the decision. They thought Administration was going to investigate alternative devices, but nothing came of that. They heard Resident #257 was upset about the removal of their rails. The rails helped the resident off load and pull themself up. Resident #257 had a trapeze, but it was a hindrance and was removed. Resident #257 went from assistance of one (1) to two (2) for bed mobility on 09/04/2025. The resident had always required assistance pf one (1) with bed mobility and used the side rail to pull themself over. All residents should have been part of the side rail conversation as it was their home, and they had the right to be informed and involved in their care plan. During an interview on 03/19/2026 at 2:05 PM, Physical Therapist #44 stated their department was told all side rails needed to be removed with the goal to have a transfer bar for those that might need them but that was never rolled out. There were no evaluations or alternatives offered before side rail removal. Side rails provided independence for some residents and when they were removed it affected their independence. Resident #257's side rails were removed because they were not independent with bed mobility. They had a therapy evaluation on 09/09/2025 after the side rails had already been removed. They went from maximum assistance of one (1) with two (2) side rails to maximum assistance of two (2) with no side rails. They thought Resident #184 had one side rail but was unsure if they used the rail or had a therapy evaluation. Resident #257 required substantial to maximum assistance with the side rail and because they were not independent the side rail was removed. During an interview on 03/19/2026 at 3:28 PM, the Director of Nursing stated in September 2025 the decision was made to become a side rail free facility. On 09/03/2025 text notifications, voice notifications and certified letters were sent out to residents and families informing them of the side rail removals. On 09/03/2025, nurse managers were provided with literature with which to educate the residents. The education was verbal and was not documented. The certified letter provided a number to call welcoming any discussions, but there was no time for discussions as the removal of the rails started the same day those notifications went out and the side rails were removed very quickly. They did not think there should have been time allotted for discussion because it was such a big facility and there were only a handful of residents that were upset. At the time the side rails were removed, those residents with side rails had been determined the side rails were appropriate, but there were too many risks, and the side rails were removed. It was easier to remove them all and then reassess if needed. No residents had a decline or required more staff assistance because of side rail removal. Resident #184 was very upset about the removal of their side rails. The resident had always been dependent on bed mobility. Even if the side rails had not made them entirely independent with bed mobility, their ability to assist with their own bed mobility could provide them with a sense of some independence. Residents had the right to an environment that allowed them to be as independent as possible, but the facility looked at safety over independence. 10 New York Codes, Rules and Regulations 415.3(c)(1)(i) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>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 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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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**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<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>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<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility failed to provide the necessary services and treatment for indwelling urinary catheter use for two (2) of six (6) residents (Residents #1 and #13) reviewed. Specifically, Resident #1 did not have a provider recommended voiding trial completed; and Resident #13 had an indwelling urinary catheter with a history of bladder infections and did not receive assistance with changing between their urinary collection leg bag (a small, wearable, and discreet receptacle used to collect urine) and a large capacity urinary collection bag. Findings include: The facility policy Foley Catheter, revised 04/21/2015, documented the facility ensured all residents with an alteration in urinary continence had been assessed and provided the interventions that best meet their needs and the physician's order would be checked for an appropriate medical justification.<br><br>There was no documented policy addressing care and maintenance of an indwelling urinary catheter.<br><br>1) Resident #1 had diagnoses including retention of urine. The 01/05/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident had moderate cognitive impairment, required substantial/ maximum assistance with most activities of daily living, and had an indwelling urinary catheter (a tube that allows urine to pass out of the body).<br><br>The Comprehensive Care Plan initiated 01/13/2026 documented the resident had a urinary catheter due to urinary retention. Interventions included the catheter was placed prior to admission on [DATE] and the catheter was changed at least monthly, signs and symptoms of urinary tract infection were monitored and reported, and the drainage bag was kept below the level of the bladder.<br><br>The 12/30/2025 Hospital Discharge Summary documented the resident had a urinary catheter in place, failed voiding trials during the hospital stay and the plan was to continue the urinary catheter on discharge and a voiding trial could be attempted at the rehabilitation facility and the resident should be referred to urology (medical specialty that focuses on the urinary system) outpatient.<br><br>The 12/30/2025 Registered Nurse Unit Manager #21's Clinical admission Assessment documented the resident had a new urinary catheter placed at the hospital for urinary retention.<br><br>The 01/02/2026 Initial History and Physical completed by Physician #4 documented the resident had a urinary catheter in place and had apparently failed three (3) voiding trials at the hospital. The plan was to follow up with urology.<br><br>There was no documented evidence an appointment for urology follow up was made.<br><br>The 01/09/2026 physician orders documented the resident had a urinary catheter for urinary retention as needed for obstruction.<br><br>There was no documented evidence of a physician order for the urinary catheter from 12/30/2025-01/09/2026.<br><br>The 01/12/2026, 01/14/2026, 01/20/2026, and 01/22/2026 Nurse Practitioner #8 progress notes documented the resident had a urinary catheter. There was no documented plan to address the urinary catheter.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 01/30/2026 physician order documented to remove the urinary catheter one time for a voiding trial. If the resident did not void during the day shift, the urinary catheter would be replaced.<br><br>The 02/02/2026 Licensed Practical Nurse Assistant Unit Manager #26 progress note documented the resident had their urinary catheter removed a 6:00 AM that morning for a voiding trial. The resident was unable to void after eight (8) hours, and the urinary catheter was replaced.<br><br>There was no documented evidence Nurse Practitioner #8 was notified of the failed voiding trial.<br><br>Medical provider progress notes documented:<br><br>- On 02/13/2026, 02/24/2026, 02/26/2026, 02/27/2026, and 03/02/2026 by Nurse Practitioner #8 the resident had a urinary catheter. There was no documented plan to address the urinary catheter. There was no documented evidence they were aware of a failed voiding trial.<br><br>-On 03/06/2026 by Physician #4 the resident had a urinary catheter in place. The plan was discussed with the team to attempt a voiding trial and if it failed, consider urology follow up.<br><br>There was no documented evidence an additional voiding trial was attempted, or a urology appointment was made.<br><br>The 03/09/2026, 03/10/2026, 03/11/2026, 03/12/2026, 03/13/2026, and 03/17/2026 Nurse Practitioner #8 progress notes documented the resident had a urinary catheter. There was no documented plan to address the urinary catheter.<br><br>During an observation and interview on 03/15/2026 at 4:20 PM, Resident #1 was seated in their recliner chair in their room. They had a urinary catheter drainage bag hanging off the recliner chair wrapped in a pillowcase. The tubing had straw colored urine in it. The resident stated they had the catheter since they were admitted to the facility.<br><br>During a follow up interview on 03/17/2026 at 10:03 AM, Resident #1 stated the urinary catheter was placed in the hospital because they could not urinate. The facility removed the catheter once, but they could not urinate, so it was put back in. They had never seen a urologist and they were not informed of any sort of plan for the urinary catheter.<br><br>During an interview on 03/17/2026 at 12:07 PM, Licensed Practical Nurse Assistant Unit Manager #26 stated if a resident was admitted to the facility without a proper diagnosis for a urinary catheter, a voiding trial was done and if that failed, the resident went to urology for a proper diagnosis. It was important residents went to urology right away because having a urinary catheter put them at high risk for infection or they could lose the ability to urinate on their own. They recalled attempting a voiding trial with Resident #1, but they failed. The medical provider should have been notified of the failed attempt, and it was documented in their progress note if it was done. They were not sure why the resident had not yet gone to urology. Unit Clerk #43 scheduled urology appointments.<br><br>During an interview on 03/17/2026 at 1:20 PM, Unit Clerk #43 stated they made outside appointments for the residents. Usually, they could get residents in for urology appointments within a couple of weeks. They were not sure why it had taken so long to get Resident #1 to urology, but they stated the resident had an appointment scheduled for 04/27/2026 (4 months after admission).<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/19/2026 at 10:03 AM, Registered Nurse Unit Manager #21 stated if a resident was admitted to the facility with a urinary catheter, a voiding trial was attempted within the first couple of weeks. If the voiding trial failed, the catheter was replaced and the resident followed up with urology. The unit clerk made the appointments but they did not document their efforts anywhere so there was no way to prove when they contacted urology for an appointment. A voiding trial required an order; they did not know why the recommended voiding trial on 03/06/2026 was not followed through. Whatever nurse this was communicated to was responsible for entering the order. The medical provider should be notified of the initial failed voiding trial, but the nursing progress note did not indicate that it was done.<br><br>During a telephone interview on 03/19/2026 at 3:25 PM, Nurse Practitioner #8 stated the facility had a protocol to attempt a voiding trial as soon as possible after admission for removal of a urinary catheter. Residents with catheters had increased risk for urinary tract infections. Resident #1 had voiding trials that failed at the hospital and one at the facility. The resident should have been sent to urology to determine what the problem was. The resident had declined a urology follow up in the past couple of weeks, and the refusals were likely not documented. The resident's family did not want any aggressive measures. They thought the resident was going to expire and the goal was to keep them comfortable, but they did not. Not all cases were black and white but if they were not going to send the resident to urology, they should have documented notes to support that, and nursing should have too.<br><br>2) Resident #13 had diagnoses including obstructive uropathy (a condition that blocks the flow of urine), bladder cancer, and bladder infection. The 02/11/2026 Minimum Data Set assessment documented the resident had intact cognition; required moderate assistance with toileting hygiene; and had an indwelling catheter.<br><br>The 07/15/2025 Comprehensive Care Plan, revised 02/19/2026, documented the resident had an indwelling urinary catheter. Interventions included position catheter bag and tubing below the level of the bladder and change catheter bag per protocol and as needed.<br><br>Physician orders documented the following:<br><br>-On 02/05/2026 change the 16 French (catheter size) urinary catheter on the 2nd of each month and as needed.<br><br>-On 2/01/2026 cefpodoxime proxetil (an antibiotic) oral tablet 100 milligrams give one (1) tablet by mouth three (3) times a day for urinary tract infection for three (3) days.<br><br>-On 03/19/2026 Bactrim DS (an antibiotic) oral tablet 800-160 milligrams give one (1) tablet by mouth two (2) times a day for urinary tract infection for five (5) days.<br><br>During an interview on 03/15/2026 at 5:58 PM, Resident #13 stated they had a leg bag and did not change to a large collection bag when going to bed. They did not know they should do so, as no one had ever explained why they should. If it was in their best interest to do so they would.<br><br>Per manufacturer specifications urinary leg bags generally measure around 10 to 13 inches in length and 3.75 to 5 inches in width and are designed to fit discreetly on the thigh or calf and are held in place with wide fabric straps. When reclined in bed the collection bag does not remain below the level of the bladder.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/17/2026 at 3:36 PM, Certified Nurse Aide #22 stated leg bags were switched to large bags at bedtime. Resident #13 independently switched back and forth between a leg and large collection bag. They did not think the resident wore a leg bag while in bed.<br><br>During a follow up interview on 03/18/2026 at 9:04 AM, Resident #13 stated they never switched their own bags before as they were told only nursing could do so.<br><br>During an interview on 03/18/2026 1:42 PM, Certified Nurse Aide #23 stated Resident #13 regularly wore a leg bag when they went to dialysis, kept it on when they returned, and went to bed with it on. They could not switch the bags themself so staff should be offering to do so. They recalled times when they found the resident in the morning in bed still wearing their leg bag.<br><br>During an interview on 03/18/2026 at 2:06 PM, Licensed Practical Nurse #24 stated leg bags should be switched to large bags when going to bed. If a resident preferred not to do so, there should be documentation that education was provided to the resident. Resident #13 had a history of bladder infections and generally liked to leave the leg bag on most of the time including when in bed. The resident depended on staff to switch the bags. If their preference was to not switch bags there should be documented education on the risks.<br><br>During an interview on 03/19/2026 at 10:34 AM, Registered Nurse Unit Manager #21 stated leg bags were not ideal when in bed due to the bag not being below the level of the bladder which could impact draining and cause backflow and infection. However, if a resident was alert and oriented and preferred to wear a leg bag to bed, they should be allowed to do so after receiving education on the associated risk. Education should be documented and their preference added to the care plan. Resident #13 had a history of bladder infections. Their bag should be positioned below their bladder and switched from a leg to a large collection bag at night, but they preferred a leg bag. The resident's care plan should document they declined to switch. They were not aware of any documented education provided to the resident regarding the associated risk or any documentation of their declinations.<br><br>10 New York Codes, Rules and Regulations 415.12(d)(1) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observations and interviews during the survey, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of four (4) Residents (Resident #197) reviewed. Specifically, Resident #197 had significant weight loss, was not assisted with meals as care planned, and there was no documented evidence a medical provider addressed the resident's weight loss.Findings included:Resident #197 had diagnoses including Alzheimer's disease and abnormal weight loss. The 01/29/2026 quarterly Minimum Data Set assessment documented the resident had severely impaired cognition, required supervision/touching assistance with eating, and had a 5% or weight loss in the last month or 10% more in the last 6 months and was not on a physician-prescribed weight-loss regimen.The 08/19/2025 Comprehensive Care Plan, revised 11/18/2025, documented the resident had inadequate oral intake related to decreased appetite and sleeping during meals as evidenced by poor recorded intakes and significant weight loss of 11 pounds in 90 days. The goal was to consume adequate intakes to support a weight goal of 115 pounds, no further weight loss, no skin breakdown, or signs or symptoms of dehydration. Interventions included providing Ensure Plus High Protein (nutritional supplement) with breakfast and evening medication pass daily and weights per provider order. The resident required assistance with self-care and mobility related tasks. Interventions included provide assistance of one staff with extensive verbal cues for encouragement. The Care Card (care instructions) documented the resident required assistance of one with extensive verbal cues for encouragement at meals and if the resident became overwhelmed in the dining room, provide a place to sit outside or the option to eat in their room. The resident's weights documented:- 10/01/2025: 128 pounds- 11/05/2025: 122.4 pounds- 12/03/2025: 119.4 pounds The 12/05/2025 Registered Dietitian #12 progress note documented the resident had a 13% weight loss in the past 180 days. The plan was to continue Ensure Plus High Protein with breakfast and at bedtime. Continue monitoring weekly weights. Staff reported the resident benefitted from encouragement and redirection during meals to promote intake. There was no documented evidence the medical provider was made aware of the resident's weight loss. The resident's weights documented:- 01/07/2026: 114.8 pounds (severe 10.3% loss in 3 months) The 01/30/2025 Registered Dietitian #12 progress note documented the resident had a 10% weight loss in 180 days but weights were stable for 30 days. The resident benefited from staff redirection during meals however continued to be preoccupied with picking at their skin. The plan was to add high protein strawberry milk with all meals and continue to monitor. The 02/04/2026 weight was documented at 115 poundsThe 02/08/2026, Registered Dietitian #12 progress note document the resident received Ensure High Protein at breakfast and at night for snack. They required the assistance/supervision of one staff member with extensive verbal cues provided for encouragement. They had a 10 percent weight loss in the last six months. Interventions included a regular diet with Ensure High Protein at breakfast and evening medication pass and to continue weekly weights.There was no documented evidence the medical provider was made aware of the resident's weight loss. The 03/11/2026 weight was documented at 114.2 pounds. The following observations were made of Resident #197 during dinner service on 03/15/2026:- At 6:04 PM spilling their drink on the table and their hands were shaking.- At 6:07 PM touching their food with their hands and not eating.- At 6:24 PM asleep at the table. They consumed 0-25% of solid food and 75% of the pink milk.- At 6:41 PM a safety aide cleaned the drink spill. No assistance or encouragement was provided.- At 6:52 PM at the table with their eyes closed and their head on their hands. The resident had no additional intake. No assistance or encouragement was provided.- At 7:06 PM Certified Nurse Aide #15 asked the resident if they were done eating and removed their meal tray. The resident consumed 0-25% of the chicken patty and cauliflower, 75% of pink milk, and 100% of the hot beverage. No assistance or encouragement was provided during the meal. The following observations were made of Resident #197 during lunch service on 03/16/2026:- At 1:23 PM the resident was served green beans, rice, strawberry milk, high protein Ensure, ice<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cream, cut up honey chicken, and Asian vegetables.- From 1:28 PM- 1:38 PM there was no assistance or encouragement provided to the resident.- At 1:48 PM the resident's eyes were closed and they did not consume anymore of the meal.- At 2:09 PM Hospitality aide #16 spoke to the resident and pointed to the Ensure then walked away.- At 2:10 PM the resident's tray was removed.During an interview on 03/19/2026 at 9:00 AM Registered Dietitian #12 stated they provided nursing a list of residents who needed to be weighed; significant weight changes were 5% change in one month, 7.5% change at three months, and 10% change at six months. Resident #197 had significant weight loss and was on supplements. The resident was care planned to receive verbal cues at meals and staff should follow the care plan.During an interview on 03/19/2026 at 9:30 AM Licensed Practical Nurse #18 stated staff reviewed the care plan, and if residents required verbal cues staff should provide cues during meals. Resident #197 did not eat a lot and needed cues and staff should be encouraging them. Staff should tell the nurse if a resident was not eating. They were not aware that the resident was not eating or receiving verbal cues.During an interview on 03/19/2026 at 9:59 AM Registered Nurse Unit Manager #19 stated the care instructions listed the level of assistance required for meals. The registered dietitian sent out an email about significant weight changes to the medical providers. Resident #197 had significant weight changes and required supervision with verbal cues at meals. Staff needed to be in line of sight of the resident and provide encouragement at meals. Staff should tell the nurse if the resident was not eating and offer alternatives. They stated medical had not addressed the resident's weight loss and they had not discussed it with the providers.During an interview on 03/19/2026 at 2:10 PM Nurse Practitioner #8 stated registered dietitians sent them an email discussing significant weight changes. They did not attend the weight meetings. They communicated with the registered dietitian electronically and tried to document the significant weight changes. Weights were reviewed monthly and they expected to be notified of significant weight loss. Resident #197 had significant weight loss six months ago and then stabilized. There was a significant change in December. In an ideal situation they would have requested a re-weight. They did not see any medical notes about the significant weight loss from December. The weight loss was likely progression of dementia. They stated staff should follow the care plan. During an interview on 03/19/2026 at 2:37 PM Certified Nurse Aide #17 stated they reviewed the care instructions to identify the level of assistance residents needed for meals. Supervision/touching assistance meant assisting the resident with eating, guiding their hands, and supervising them. Verbal cues of encouragement at meals were to get them to eat. Resident #197 required verbal cues and sometimes assistance. They did not assist the resident with meals on 03/15/2026 and believed the resident did not eat much. The resident was not on the list to assist with meals. They should have provided verbal cues if they were not eating. 10 New York Codes, Rules and Regulations 415.12(i)1 |

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| | 335431 | A. Building<br>B. Wing | 03/20/2026 |

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| Samaritan Keep Nursing Home Inc | 133 Pratt St<br>Watertown, NY 13601 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, record review, and interviews, the facility failed to ensure residents who needed respiratory care were provided with such care, consistent with professional standards of practice for one (1) of one (1) resident (Resident #257) reviewed. Specifically, Resident #257 had a bilevel positive airway pressure machine (non-invasive mechanical ventilator that keeps airway open when sleeping) that was not cleaned per professional standards; was not maintained with water in the reservoir; did not have an order for supplemental oxygen use when used; was not documented as administered on the medication administration record; and there was no documented evidence of ongoing assessment of the resident's respiratory status, response to the therapy, documentation of the equipment settings or when to use the equipment.Findings include:The facility policy CPAP (continuous positive airway pressure) BIPAP (bilevel positive airway pressure) Therapy, revised 06/01/2021, documented the facility would provide bilevel positive airway pressure therapy in accordance with physician orders, manufacturer guidelines, and evidence-based practice to maintain resident safety, respiratory stability, and quality of life; the mask must be taken off daily and cleansed with a wet cloth; and use of bilevel positive airway pressure would be documented on treatment record.The facility policy Oxygen Delivery, revised 06/18/2025, documented an order would be obtained for use of low flow oxygen of one (1) to six (6) liters and oxygen administered by a concentrator would be placed in the treatment administration record.Resident #257 had diagnoses including respiratory failure and obstructive sleep apnea (a condition where sleep is interrupted by abnormal breathing). The 02/26/2026 Minimum Data Set assessment documented the resident had intact cognition; was dependent for most activities of daily living; had shortness of breath with exertion, at rest and when lying flat; and received oxygen therapy and non-invasive mechanical ventilation.The 12/02/2021 Comprehensive Care Plan, revised 12/18/2025 documented the resident required constant oxygen with bilevel positive airway pressure related to respiratory failure. Interventions included monitor for signs of respiratory distress, and oxygen to be bled through bilevel positive airway pressure at five (5) liters a minute (introducing supplemental oxygen into the air stream via an oxygen enrichment port or bleed-in adapter, usually to treat low blood oxygen saturation during sleep apnea treatment).Physician orders documented the following:-On 09/26/2021 check water level in the bilevel positive airway pressure machine every shift.-On 11/13/2023 bilevel positive airway pressure settings 22/18. Order for new bilevel positive airway pressure and all supplies revised.-On 02/07/2024 did the resident have shortness of breath or trouble breathing while lying flat and/or kept the head of their bed elevated/slept in a recliner due to shortness of breath or trouble breathing while lying flat? Document every shift.The physician orders did not document when to use the bilevel positive airway pressure equipment or include directions for oxygen bleed in. Additionally, the administration of the bilevel positive airway pressure and its settings was not being documented.The March 2026 Treatment Administration Record documented the water level in the bilevel positive airway pressure machine was not checked every shift as ordered on 03/01/2026, 03/03/2026, 03/06/2026 - 03/08/2026, 03/09/2026, 03/10/2026, 03/14/2026 and 03/15/2026. The Treatment Administration Record did not document whether the resident had shortness of breath or trouble breathing while lying flat and/or kept the head of their bed elevated/slept in a recliner due to shortness of breath or had trouble breathing while lying flat as ordered on 03/01/2026, 03/03/2026, 03/06/2026- 03/10/2026, 03/14/2026, and 03/15/2026.During an observation and interview on 03/15/2026 at 3:44 PM the water reservoir of the bilevel positive airway pressure machine was empty; the nasal mask had dried brown debris on the inside; and the oxygen concentrator was set at five (5) liters and was piped into the bilevel positive airway pressure tubing. The resident stated they used their bilevel positive airway pressure all the time and the nasal mask was never cleaned.During an observation on 03/16/2026 at 1:53 PM the water reservoir of the bilevel positive airway pressure machine was empty.During an observation on 03/18/2026 at 9:37 AM the resident was using their<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bilevel positive airway pressure and the oxygen concentrator was piped into the bilevel positive and set at four and a half (4.5) liters.The March 2026 Treatment Administration Record documented Licensed Practical Nurse #20 signed they checked the water level of the bilevel positive airway pressure on 03/16/2026 during the day shift.During an observation and interview on 03/17/2026 10:04 AM the resident's bilevel positive airway pressure machine was filled with clear fluid; the oxygen concentrator was set at four and a half (4.5) liters and was being piped into the bilevel positive airway pressure tubing; and the nasal mask had dried brown debris on the inside. The resident stated they could tell the water reservoir was full as their nares did not feel dry as they had the last couple of days.During an observation on 03/19/2026 at 10:02 AM, the oxygen concentrator was set at four and a half (4.5) liters and was being piped into the bilevel positive airway pressure tubing.During an interview on 03/19/2026 at 1:07 PM, Licensed Practical Nurse #20 stated they were unsure what Resident #257's bilevel positive airway pressure orders were; they did not have to verify the settings were correct; they thought the mask was supposed to be cleaned monthly and did not know who was responsible to do so; and the mask was only changed if broken. They stated they filled the water reservoir with water during the day shift on 03/16/2026 and was unsure why it was empty.During an interview on 03/19/2026 at 12:03 PM, Licensed Practical Nurse #24 stated oxygen required an order and the setting should be checked once a shift. Nursing was responsible for maintaining the correct bilevel positive airway pressure settings and the water reservoir was full. The bilevel positive airway pressure mask was rinsed out weekly with water and replaced if it stopped working or was filthy beyond repair. There was no special respiratory assessment other than checking oxygen levels every shift. Resident #257 used bilevel positive airway pressure all the time and had five (5) liters of oxygen piped into it. Nursing checked the settings, but they did not document the use or the settings. They did not keep any back up supplies for the bilevel positive airway pressure device on hand and if they needed something they would have to call respiratory across the street. During an interview on 03/19/2026 at 1:45 PM, Registered Nurse Unit Manager #21 stated oxygen required an order and they expected the nurses to ensure the settings were correct. They were unsure who was supposed to clean the bilevel positive airway pressure masks or how often. The water reservoir created humidification and should not be dry. They expected the nurses to know what bilevel positive airway pressure and oxygen settings were and they were set correctly. The bilevel positive airway pressure order was not scheduled and therefore not signed for by nursing, but it should be. They were unsure how the effectiveness of the bilevel positive airway pressure was monitored as there was nothing in place other than checking their oxygen level on the night shift. 10 New York Codes, Rules, and Regulations 415.12(k)(6) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on observation, record review, and interviews, the facility failed to ensure that a resident who required dialysis (a process that filters blood during kidney failure) received services consistent with professional standards of practice for one (1) of one (1) resident (Resident #13) reviewed. Specifically, Resident #13 received dialysis at a community-based dialysis center, and the facility did not perform ongoing assessments of their condition or monitor for complications before and after dialysis treatments and there was inconsistent communication between the dialysis center and the facility. Findings include: The facility policy Dialysis, revised 03/01/2023, documented communication with the dialysis team would be maintained to ensure quality care of the resident; the purpose of the communication book was to share information/ask questions, not requiring immediate responses with the dialysis center; the unit manager/designee was responsible for writing in the communication book; and the resident would be monitored for such things as signs of fluid retention or dehydration, findings documented, and physician notified as appropriate. Resident #13 had diagnoses including kidney failure. The 02/11/2026 Minimum Data Set assessment documented the resident had intact cognition and received dialysis. The 07/03/2025 Comprehensive Care Plan, revised 08/21/2025, documented the resident needed hemodialysis related to kidney failure. Interventions included monitor intake and output, monitor labs and report to the doctor as needed, and monitor/document/report signs/symptoms of renal insufficiency. There was documented evidence the plan included monitoring pre and post dialysis, checking the dialysis access site, or ongoing communication with the dialysis center. Physician orders documented the following:-An undated order for hemodialysis every Monday, Wednesday, and Friday. -On 08/22/2025 notify the physician if systolic blood pressure (upper number on blood pressure reading) was less than 90 or the heart rate was greater than 110 (beats per minute) every shift. There was no documented evidence blood pressures were checked/monitored every shift as ordered or vital signs were obtained before and after dialysis treatments. The March 2026 Medication Administration Record documented check right chest permacath (access site for dialysis) for bleeding every shift, if bleeding apply pressure and notify physician. The Medication Administration Record documented the permacath was checked every day on all three shifts from 03/01/2026-03/18/2026. During an interview on 03/15/2026 at 5:58 PM, Resident #13 stated when they returned from dialysis no one ever checked their vital signs or looked at their dialysis access site. During an observation on 03/16/2026 at 3:05 PM, the resident returned from dialysis and self-propelled to their room. The resident had a venous access site for dialysis located on their right chest. The site was covered with a dry dressing. Their dialysis binder was in a bag connected to the back of their wheelchair and contained a post dialysis weigh form, a photocopy of their medical order for life sustaining treatment, a face sheet, and a printout of orders effective 02/06/2026. It did not include communication between the facility and the dialysis care center regarding medication administration (initiated, administered, held or discontinued) by the nursing home and/or dialysis facility, physician/treatment orders, laboratory values, vital signs, or dialysis treatment provided and resident's response. During an interview on 03/17/2026 at 1:42 PM, Licensed Practical Nurse #20 stated before sending a resident to dialysis they made sure the resident ate, took their medications and had their dialysis binder containing updated orders with them. They did not have to communicate vital signs, last meal, glucose level, or what medications were taken to the dialysis center. They did not usually get communication sheets or any type of report from the dialysis center unless the resident was sent to the emergency room. If there was no communication from the dialysis center, they assumed everything went smoothly. Taking vital signs before or after going to dialysis was not a requirement. They sent Resident #13 to dialysis on 03/16/2026. They did not check the dialysis binder upon return. The resident verbally reported their post dialysis weight which they documented. They did not recall if they checked to make sure the physician orders were updated before sending the resident. They should have gone with updated orders because the<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 02/06/2026 orders did not reflect medication orders that had been made since then including changes to their Eliquis (a blood thinner). During an interview on 03/18/2026 at 10:54 AM, Registered Nurse Manager #21 stated the licensed practical nurse assigned to the dialysis resident was responsible for making sure their dialysis binder went with them and contained updated orders; the facility was not required to check pre or post dialysis vital signs; there was not a communication form between the facility and the dialysis center; and the dialysis center performed their own vital signs and weights that were supposed to be documented in the binder. They expected if anything unusual happened while at dialysis then they would receive a phone call from the center but that did not always happen. Because their dialysis residents were alert and oriented, they were able to report if something unusual happened. If a resident had a problem like hypotension during dialysis, then that should be monitored upon their return but there was not a policy outlining that. Resident #13 went to dialysis three (3) times a week and should have updated orders in their binder. 10 New York Codes, Rules and Regulations 415.12(k) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for two (2) of seven (7) medication carts (8th floor and 4th floor medication carts); one (1) of four (4) medication rooms (4th floor medication room); and one (1) of seven (7) treatment carts (3rd floor treatment cart) reviewed. Specifically, one medication cart on the 8th floor was unlocked and unsupervised; one medication cart on the 4th floor contained pre-poured, unlabeled medications; the 4th medication room refrigerator contained an open, undated multi-dose tuberculin purified protein derivative vial; and the 3rd floor treatment cart was unlocked and unattended.Findings included:The facility policy Storage of Medications, last reviewed 02/10/2026 documented medication supply was only accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies were locked when they were not attended by persons with authorized access. Outdated, contaminated, or deteriorated medications were immediately removed from inventory, disposed of according to procedures for medical disposal, and reordered from the pharmacy.The manufacturer recommendation documented a vial of tuberculin purified protein derivative which has been entered and in use for 30 days should be discarded.4th floorDuring an observation and interview on 03/17/2026 at 3:38 PM a 4th floor medication cart top drawer contained two white circular tablets in an unlabeled plastic cup. Licensed Practical Nurse #25 stated a resident was supposed to receive them at 4:00 PM but the resident went to bingo. They should have labeled the cup, but they knew who the medications were for.During an observation and interview on 03/17/2026 at 3:43 PM the 4th floor medication room refrigerator had an open vial of tuberculin purified protein derivative with a dispensed date of 01/20/2025. Licensed Practical Nurse #25 stated any multi-dose vial should be labeled with the open date. They were not sure how long the vial was good for after it was opened.During an interview on 03/17/2026 at 4:02 PM Licensed Practical Nurse Assistant Unit Manager #26 stated multi-dose vials should be dated when opened. They had one vial of tuberculin purified protein derivative on the unit. The solution was good 28 days after it was opened. If there was no date then it needed to be discarded. The solution was used for newly admitted residents, and the unit did have admissions in the last 30 days. They stated medications should not be pre-poured; there was no way to know what the medications were and the medications in the cup should have been discarded and not saved for later. During an interview on 03/19/2026 at 10:03 AM Registered nurse Unit Manager #21 stated if medications were put into a medication cup and the resident was not available the medications should be discarded. It was never appropriate to leave a medication cup with pills in the medication cart for administration later. Tuberculin purified protein derivative vials should be dated when opened and were only good for 30 days. The nurse was expected to check the expiration date prior to administration. The nurse should have discarded the vial and ordered a new one once they saw it had no open date. 8th floorDuring an observation on 03/18/2026 from 12:25 PM-12:35 PM the 8th floor medication cart, located across from room [ROOM NUMBER], was unlocked and unattended. Multiple residents and unlicensed staff walked past the unlocked and unattended medication cart.During an interview on 03/18/2026 at 12:36 Licensed Practical Nurse #18 stated the cart was unlocked and contained medications and should not be unlocked. They stated they walked away and did not realize the cart was unlocked. They were trained on medication storage and knew it was supposed to be locked.During an interview on 03/18/2026 at 1:34 Registered Nurse Unit Manager #19 stated medications carts should be locked for safety of the residents and to prevent medication diversion.3rd floorDuring an observation on 03/18/2026 at 6:59 AM the 3rd floor treatment cart was unlocked and unattended. The cart contained<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an electric razor, a gait belt, multiple medicated creams, sunscreen, alcohol prep pads, and wound gel. During an interview on 03/18/2026 at 1:43 PM Licensed Practical Nurse #27 stated the treatment cart was supposed to be locked when unattended. They did not do treatments on night shift and did not know why it was unlocked. The unit had residents that wandered, and the treatment cart should be locked for safety reasons.During an interview on 03/19/2026 at 11:41 AM Registered Nurse Unit Manager #6 stated medication carts and treatments carts should be locked when unattended so residents could not get in them. The treatment cart had skin prep, alcohol wipes, antibacterial cream, iodine swabs and normal saline, all potentially dangerous for residents and staff. 10 New York Codes, Rules and Regulations 415.18(d) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>Based on observations, record review, and interviews, the facility failed to ensure residents received and the facility provided a diet in a form designed to meet individual needs for one (1) of one (1) resident (Resident #241) reviewed. Specifically, Resident #241 received a whole regular brownie instead of a pureed brownie as ordered; and the resident's person-centered Comprehensive Care Plan did not include the ordered altered food consistency. Findings include:The facility policy Altered Consistency-Texture Modified Diet-Dysphagia difficulty swallowing) Management, reviewed 04/02/2025, documented residents received food and fluids in a consistency that was safe, palatable, and met their nutritional needs, in accordance with physician orders, clinical assessment, and regulations of the New York State Department of Health. Texture-modified diets and fluid consistencies were implemented as clinically indicated and reduced the risk of aspiration, choking, and malnutrition, while resident rights and preferences were honored. Food texture level Pureed (Level 1) was homogeneous, cohesive, pudding like foods that required minimal chewing. Dietary services ensured all food and fluids met ordered consistencies and were prepared to maintain safety. After the Speech Language Pathologist's evaluation, diet orders, interventions, and care plans were updated in the electronic medical record. Resident #241 had diagnoses including dementia, pneumonia, and difficulty swallowing. The 01/15/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident had moderate cognitive impairment, required supervision or touching assistance with eating, and was on a mechanically altered diet. The Comprehensive Care Plan initiated 05/15/2025 and revised 03/16/2026 documented the resident had impaired swallowing related to impaired movement of solids and liquids from the mouth to the stomach as evidenced by coughing with thin liquids and difficulty chewing solids. Interventions included encouraging the resident to eat in the dining room, diet was provided per order, and thin liquids (no straws). The Comprehensive Care Plan did not document the ordered food texture. The 12/20/2025 physician order documented the resident was to receive a level one (1) pureed texture, regular (thin) consistency diet. The 01/01/2026 Speech Language Pathologist #30 Speech Therapy Evaluation and Plan of Treatment documented the resident tolerated their current diet consistencies of level one (1) solids (pureed)/ thin liquids. The resident had absent mastication (chewing) skills when provided with level (2) mechanical soft food. The recommendation was the current diet consistency was continued. The resident was not appropriate for a diet upgrade. The resident's 03/17/2026 lunch meal ticket documented one (1) mint brownie pureed. During an observation on 03/17/2026 at 1:30 PM, Resident #241 was in the dining room eating their lunch. They were not in reach of any other residents' food items. Their main lunch plate had pureed items. To the right of the lunch plate was a smaller plate with an untouched regular consistency brownie with green frosting. At 1:32 PM, the resident was coughing. Speech Language Pathologist #31 was walking through the dining room and asked the resident if they were ok. After looking at their meal ticket, the Speech Language Pathologist picked up the regular consistency brownie and took it to Food Service Worker #32 and asked them for a pureed brownie. Speech Language Pathologist #31 placed the pureed brownie in front of the resident and told them what it was. During an interview on 03/17/2026 at 1:35 PM, Speech Language Pathologist #31 stated they noticed Resident #241 was coughing so they checked their meal ticket, and saw the resident was on a pureed diet with a regular consistency brownie in front of them. The resident had dementia and had forgotten how to eat. It was important that food consistency was followed as choking was silent and could happen quickly. They did not normally monitor the dining room but just happened to be there at that time. During an interview on 03/17/2026 at 1:41 PM, Certified Nurse Aide #33 stated all food items on the meal ticket were placed on the tray by dietary. After all items were placed on the food tray, the staff who picked up the tray and delivered it also double checked for accuracy that the ticket matched the items on the tray. Sometimes things were<br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | missed. Resident #241 was on a pureed diet and should not have a regular consistency brownie. It was important the residents were served the correct items and consistencies to make sure there was not a choking hazard. During an interview on 03/17/2026 at 1:53 PM, Food Service Worker #32 stated when they plated meal items they looked at the meal ticket. There were four (4) food levels. If a ticket called for a pureed brownie, the resident should not receive a regular brownie. The food levels were followed because each resident had different health reasons. If a resident on a pureed diet received whole food, they could choke. It was extremely important the guidelines were followed. They did not recall plating a regular brownie on Resident #241's tray. During an interview on 03/19/2026 at 9:27 AM, Licensed Practical Nurse Assistant Unit Manager #26 stated the food server plated the items listed on the meal ticket and the certified nurse aide also read the ticket so there were two (2) eyes to ensure the resident received the proper diet and consistency. Resident #241 was on a pureed diet and should not have a regular consistency brownie. Orders were expected to be followed, and they did not want the residents to choke or aspirate. During an interview on 03/19/2026 at 10:03 AM, Registered Nurse Unit Manager #21 stated the certified nurse aides read the meal ticket to the server, the server looked at the ticket and placed the items on the tray. The staff member who delivered the meal also checked the accuracy of the ticket. Resident #241 was on a pureed diet and should not have a regular consistency brownie. With so many checks, they were not sure how this could have been missed. Residents were on altered diets for a specific reason, there was a medical order, and that medical order was expected to be followed. During an interview on 03/19/2026 at 10:11 AM, the Food Service Director stated the food server referenced the meal ticket and put the items on the tray. The certified nurse aides ensured the accuracy of the items on the tray to match the meal ticket. There was a two (2) point check. Training was done both through the certified nurse aide training as well food service worker training upon hire. They heard Resident #241 received a regular consistency brownie, and they should not have. Food consistencies were followed for the safety of the resident. 10 New York Codes, Rules, and Regulations 415.14(d)(3) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335431 | A. Building<br>B. Wing | 03/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Samaritan Keep Nursing Home Inc | 133 Pratt St<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of one (1) resident (Resident #1) reviewed. Specifically, Resident #1 was on transmission-based precautions (enhanced barrier precautions) and Certified Nurse Aide #37 did not perform hand hygiene prior to entering the resident's room, emptied the resident's urinary catheter without wearing required personal protective equipment, and did not perform hand hygiene with glove changes. Findings include: The facility policy Enhanced Barrier Precautions, reviewed 03/06/2026, documented any resident with an indwelling medical device such as a urinary catheter was placed on enhanced barrier precautions. Personal protective equipment including gloves and gown was required to be worn during any high contact resident care activities that included care of a urinary catheter. Face protection may also be worn if needed if performing an activity with a risk of splash or spray. Signage was present on the wall outside the resident's room and indicated the type of precaution, the required personal protective equipment, and the high contact resident care activities that required personal protective equipment. The facility's Enhanced Barrier Precaution signage posted on the wall outside the resident room doors documented everyone must clean their hands, before entering and when leaving the room; providers and staff must also wear gloves and a gown for high contact resident care activities including dressing; bathing/ showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; and device care of use of central lines, urinary catheters, feeding tube, tracheostomy; and wound care. The same gown and gloves were not worn for the care of more than one person. Resident #1 had diagnoses including retention of urine. The 01/05/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident had moderate cognitive impairment, required substantial/ maximum assistance with most activities of daily living, and had an indwelling urinary catheter. The Comprehensive Care Plan initiated 01/13/2026 documented the resident had a urinary catheter due to urinary retention. Interventions included the catheter was placed prior to admission on [DATE] and the catheter was changed at least monthly, signs and symptoms of urinary tract infection were monitored and reported, and the drainage bag was kept below the level of the bladder. During an observation and interview on 03/17/2026 at 11:11 AM, the wall to the left of the door to Resident #1's room had an enhanced barrier precaution sign posted. Certified Nurse Aide #37 entered Resident #1's room and addressed the resident. They did not perform hand hygiene prior to entering the resident's room. At 11:12 AM, the certified nurse aide stated they had to find alcohol pads as they could not find any in the room. They took their gloves off, disposed of them in the trashcan, and left the room. They stated they did not perform hand hygiene upon exiting the room. At 11:14 AM, Certified Nurse Aide #37 returned to the room and put on gloves. They did not perform hand hygiene prior to entering the room. They closed the door to the resident's room. There was a yellow caddy on the door with gowns and gloves. They entered the resident's bathroom and dumped a graduated cylinder of urine into the toilet. They depressed the flushing mechanism with a gloved hand and rinsed the graduated cylinder. They put a hand towel on the floor and placed the graduated cylinder on the towel. At 11:15 AM, they placed alcohol pads on the towel on the floor. Resident #1 was seated in their recliner to the left of their bed. The certified nurse aide unclamped the tubing to the resident's catheter drainage port and emptied the urine into the graduated cylinder, re-clamped the tubing and wiped the drainage port with an alcohol wipe. At 11:16 AM, they placed the drainage bag in a privacy bag and hung it from the recliner chair. They did not wear a gown when emptying the urinary drainage bag. They measured the urine, entered the bathroom, dumped the urinary drainage and flushed the toilet. At 11:17 AM, the certified nurse aide took both gloves off and put a new glove on their right hand. They did not perform hand hygiene in between the glove change.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 11:18 AM, they picked up the towel from the floor with their gloved right hand and walked halfway down the hallway to a soiled linen bin to discard the towel. They did not perform hand hygiene upon exiting the room. During an interview on 03/17/2026 at 11:19 AM, Certified Nurse Aide #37 stated the yellow caddy had always been on the resident's door and it was there so they could get a gown to put on. They did not put a gown on because they did not think the resident had any sickness. They stated they should have performed hand hygiene before putting on gloves and in between glove changes but it slipped their mind. Hand hygiene was the biggest thing that could break the link of infection, and it kept away germs. They stated based on the enhanced barrier sign, they should have put a gown on. They learned about precautions when they first started but there was no training since then. During an interview on 3/17/2026 at 11:27 AM, Licensed Practical Nurse #34 stated personal protective equipment was only worn with urinary catheter care if a resident had an active infection. They were not sure what enhanced barrier precautions were but there were signs outside the residents' rooms that told them when and what personal protective equipment was required. During an interview on 3/17/2026 at 12:07 PM, Licensed Practical Nurse Assistant Unit Manager #26 stated enhanced barrier precautions were new this year. The Infection Preventionist was working hard on education and staff had badge backers to reference because it was hard to remember it all. Anyone with a medical device was on enhanced barrier precautions and staff were expected to look for the sign and follow the sign. Resident #1 had a urinary catheter and was on enhanced barrier precautions. Wearing gloves did not eliminate the need for hand hygiene. A gown, gloves, mask, and face shield should be worn with catheter care. This protected residents and staff and prevented the spread of infection. During an interview on 03/20/2026 at 9:29 AM, the Infection Preventionist stated hand hygiene should be performed before and after any resident contact. Gloves did not negate the need for hand hygiene, and it was the single most important thing for infection control and preventing the spread of pathogens. Staff were expected to read the signage and follow it every time. If staff performed any high contact activity that included urinary catheter care, they should wear a gown, gloves, and a face shield if there was a splash risk. All staff were educated on enhanced barrier precautions upon hire, annually, and as needed to protect the residents, staff, and prevent the spread of infection. 10 New York Codes, Rules, and Regulations 415.19(a)(b) |