STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335615	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Manor Nursing Home	1172 Long Pond Road Rochester, NY 14626

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observations, interviews, and record review, the facility failed to ensure alleged violations involving abuse were responded to timely and failed to ensure residents were protected from potential further abuse while the investigation was in progress for one (1) of four (4) residents reviewed (Resident #1). Specifically, Certified Occupational Therapy Assistant #1 reported on 04/28/2026 they witnessed Certified Nursing Assistant #1 strike Resident #1 on the head on 04/24/2026. The allegation was not immediately reported as required by facility policy, which delayed initiation of the facility investigation and delayed removal of Certified Nursing Assistant #1 from resident access pending investigation. The findings include:The facility Abuse, Neglect, and Exploitation Prohibition, Training, Investigation, and Reporting Policy, dated December 2016, included a staff person who witnesses or suspects abuse involving a resident must immediately report the suspicion to their immediate supervisor. The facility must prevent further potential abuse while the investigation is in progress. Resident #1 had diagnoses including Alzheimer's disease (a progressive brain disease affecting memory and thinking skills), epilepsy (a neurological disorder causing seizures), and vascular dementia (a decline in thinking skills caused by reduced blood flow to the brain). The Comprehensive Minimum Data Set (a resident assessment tool) dated 03/17/2026 documented Resident #1 had severe cognitive impairment.Review of Certified Nursing Assistant #1's employee disciplinary records revealed on 02/11/2026 a final written warning was issued for unprofessional interactions with residents and families, unprofessional attitude toward peers and management, and inability to care for certain residents due to poor interactions.Review of employee education records revealed Certified Nursing Assistant #1 and Certified Occupational Therapy Assistant #1 received facility training related to abuse prohibition and reporting requirements.Review of Certified Nursing Assistant Assignment Sheets revealed Certified Nursing Assistant #1 was assigned to Resident #1's care on the day shift on 04/24/2026. Additional review revealed Certified Nursing Assistant #1 worked on Resident #1's unit on 04/27/2026 and 04/28/2026.Review of Certified Nursing Assistant #1's time records revealed they worked on 04/24/2026 from 7:45 AM until 2:50 PM, on 04/27/2026 from 6:53 AM until 2:36 PM, and on 04/28/2026 from 7:49 AM until 10:14 AM.Review of the facility report submitted to the New York State Department of Health Incident Reporting Portal on 04/28/2026 at 11:23 AM documented the incident occurred on 04/24/2026 at 12:15 PM and the Administrator first became aware of the allegation on 04/28/2026 at 9:45 AM. The report further documented Certified Occupational Therapy Assistant #1 reported they witnessed Certified Nursing Assistant #1 swat Resident #1 on the head.Review of facility investigation records included a statement from the Director of Rehabilitation, dated 04/28/2026 which revealed Certified Occupational Therapy Assistant #1 reported the allegation to the Director of Rehabilitation on 04/28/2026 at approximately 9:10 AM and facility leadership was then notified. Additional review of investigation records revealed Certified Nursing Assistant #1 and Certified Occupational Therapy Assistant #1 were suspended pending investigation on 04/28/2026. Review of the facility investigation dated 04/28/2026 revealed Resident #1 was unable to provide a statement and had no recollection of the incident, Certified Nursing Assistant #1 denied the allegation, and concluded the allegation of abuse was unable to be determined.During an interview on 05/05/2026 at 1:22 PM, Certified Occupational Therapy Assistant (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 stated on 04/24/2026 at approximately 12:15 PM they observed Certified Nursing Assistant #1 strike Resident #1 on the top of the head in the dining room. Certified Occupational Therapy Assistant #1 stated they did not immediately report the incident because they were concerned Certified Nursing Assistant #1 would get in trouble. Certified Occupational Therapy Assistant #1 stated they reported the allegation to the Director of Rehabilitation on 04/28/2026.During an interview on 05/05/2026 at 1:02 PM, the Director of Rehabilitation stated Certified Occupational Therapy Assistant #1 reported on 04/28/2026 they witnessed Certified Nursing Assistant #1 strike Resident #1 on 04/24/2026. The Director of Rehabilitation stated they immediately notified the Acting Director of Nursing. During an interview on 05/05/2026 at 8:53 AM, Registered Nurse Manager #1 stated if abuse is observed, the expectation is the resident is removed from the situation immediately, a supervisor is notified immediately, and the Administrator is notified so the incident can be properly reported. During an interview on 05/05/2026 at 2:59 PM, the Administrator stated staff are expected to immediately report allegations of abuse, neglect, or mistreatment to a supervisor and the incident involving Certified Nursing Assistant #1 and Resident #1 should have been reported immediately when it occurred on 04/24/2026.Title 10 New York Codes, Rules and Regulations 415.4(b)(1)(i), (3)