

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER New York State Veterans Home at Montrose		STREET ADDRESS, CITY, STATE, ZIP CODE 2090 Albany Post Road Montrose, NY 10548	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews during an abbreviated survey (NY00375411) the facility did not ensure the resident was free from abuse for 1 out of 3 residents (Resident #1) reviewed for abuse. Specifically, on 3/15/2025 Resident #1 was seen on Facility Surveillance Camera Footage wandering the hallway to the adjacent unit. Resident #1 was seen going in and out of other resident's rooms. Security Officer #1 was observed grabbing Resident #1 by their wrist to keep the resident in one place. Licensed Practical Nurse #1 was observed grabbing both of Resident #1's wrists and Certified Nurse Assistant #2 and Registered Nurse #2 grabbed Resident #1's right arm while Registered Nurse #1 was seen administering an injection to the resident while staff hold the resident in place against the wall in the hallway. Resident #1 is observed on surveillance camera footage in a wheelchair and trying to propel themselves away from the staff. Resident #1 was seen with all four of their extremities held by four staff members (Certified Nurse Aide #2, the Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2) preventing the resident's movement. Staff was seen wheeling the resident back to their room holding on to all four extremities</p> <p>The findings are:</p> <p>The facility Abuse Prohibition policy last revised 9/2023 documented the facility shall take actions to prevent abuse by identifying, correcting and intervening in situations in which abuse is more likely to occur. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse may be verbal, sexual, physical or mental.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including but not limited to Parkinsonism, Anxiety Disorder and Depression.</p> <p>An Admission Minimum Data Set, dated dated [DATE] the resident was cognitively intact. The resident required a walker and a wheelchair for locomotion, set up assistance with eating and bed mobility, moderate assistance with toileting and independent with transfers.</p> <p>There was no Abuse care plan initiated by the facility prior to the incident</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a psychosocial well-being care plan dated 3/13/2025 documented Resident #1's well-being as positively able to verbalize needs, engages in conversation with others, and has a supportive family who visits. Resident #1 is negatively impacted by increase in confusion, sundowning (a collection of behaviors such as difficulty sleeping, anxiety, agitation, and restlessness that occurs from dusk through night), and declining health status. Interventions listed included to monitor effectiveness of approaches, provide support and show interest in well-being through verbalization and supportive techniques, identify conflicts and apply appropriate approaches for resolution. No specific approaches were documented on the care plan.</p> <p>Review of a mood care plan dated 3/13/2025 documented Resident #1 had potential for mood issues related to diagnoses of anxiety, sundowning (a collection of behaviors such as difficulty sleeping, anxiety, agitation and restlessness) that occurs from dusk through night) and Parkinson's disease. Resident #1 expressed feeling down, depressed or hopeless, feeling tired or having little energy, poor appetite and having trouble falling asleep or staying asleep, or sleeping too much. Interventions listed included assess and monitor resident to determine onset of mood problem, assist resident in managing feelings by having staff available during upset episodes, encourage to verbalize concerns, try to get resident to identify unmet needs, do not negate residents' feelings and let it be known that efforts will be made to relieve anxieties and concerns. Acknowledge difficulty adjusting to facility, establish foundation for trust and support and involve significant individuals in life as support while dealing with mood issues.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility Surveillance Camera Recording dated 3/15/2025 revealed at 5:42 AM Resident #1 was standing in the hallway of the unit, wearing a T-shirt, briefs and tennis shoes. At 5:50 AM Resident #1 is seen wandering around the unit and enters another resident's room. Registered Nurse #1 is observed trying to redirect Resident #1. At 5:51 AM Security Officer #1 is seen in the hallway grabbing Resident #1 by both wrists and attempting to keep Resident #1 in one place. Registered Nurse #2 is seen witnessing the incident. At 5:52 AM Resident #1 broke free from Security Officer #1 and walked down the hallway. Security Officer #1 and Registered Nurse #2 are seen following the resident. At 6:03 AM Resident #1 is seen getting up from a chair and walking down the hallway with Registered Nurse #2 walking closely behind. Resident #1 continues to wander the hallway to another unit. Registered Nurse #2 is seen trying to redirect the resident. At 6:07 AM Certified Nurse Aide #2, Licensed Practical Nurse #1, Security Officer #1 and Registered Nurse #2 show up with a wheelchair and they were seen trying to get Resident #1 to sit down in the wheelchair. At 6:09 AM Resident #1 was seen wandering the hallway with Registered Nurse #2, Security Officer #1 and Certified Nurse Aide #2 following behind. Resident #1 sat in a recliner in the common area. Security Officer #1 and Certified Nurse Aide #1 are seen standing in front of the seated resident. At 6:11 AM Registered Nurse #1 was seen attempting to administer oral medication to Resident #1, which they refused. At 6:13 AM Licensed Practical Nurse #2 tries to administer the oral medication, and the resident appears to swing at Licensed Practical Nurse #2. Between 6:13 AM and 6:19 AM, Certified Nurse Aide #2 and Security Officer #1 are observed standing in the common area with Resident #1. Between 6:21 AM and 6:23 AM, Certified Nurse Aide #2 leaves and Resident #1 stands from the chair and sits back down. At 6:26 AM, Resident #1 gets up from the chair and Security Officer #1 was attempting to stop the resident by blocking their path with a wheelchair. At 6:27 AM four (4) staff members (Certified Nurse Aide #2, Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2) were observed assisting with sitting Resident #1 in a wheelchair. Resident #1 attempts to propel the wheelchair with their hands and legs and Certified Nurse Aide #2, Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2 each grab Resident #1 by their extremities. Resident #1 is then seen swinging their arms and attempting to get free from the restraint of the staff members. Resident #1 is seen kicking at Registered Nurse #1 and attempted to remove Security Officer #1's hand from their wrist. Resident #1 continues to kick and attempt to remove the staffs' hold of their arms. At 6:27 AM Licensed Practical Nurse #1 is seen holding Resident #1 by the left arm, Registered Nurse #2 is standing to the right of the resident, Certified Nurse Aide #2 is standing behind the resident putting on gloves. Licensed Practical Nurse #1 proceeds to grab both of Resident #1's wrist, while holding the resident against the wall in the hallway. Certified Nurse Aide #2 and Registered Nurse #2 proceed to grab Resident #1's right arm and Registered Nurse #1 is seen administering an injection to Resident #1.</p> <p>At 6:29 AM Certified Nurse Aide #2, Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2 are seen moving Resident #1 down the hall while physically restraining the resident's extremities. Registered Nurse #1 is seen following behind. Resident #1 was brought back to the unit and into the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an undated Facility Incident Report submitted on 3/18/2025 at 12:30 PM documented the incident occurred on 3/15/2025 at 6:27 AM and the Administrator was made aware of the incident on 3/18/2025 at 10:00 AM. Resident #1 was walking around their unit in a shirt and brief on 3/15/2025 at approximately 5:43 AM. Resident #1 was not able to be re-directed by the nurse and entered another resident's room. Security and the supervisor were called for assistance. Resident #1 went to the adjoining unit and entered at least two other resident's rooms. At some point Resident #1 attempted to close the door of another resident's room on the supervisor's arm. Orders were received for oral Ativan and Haldol intramuscularly. Resident #1 spit out the oral Ativan and the Haldol was administered intramuscularly. Resident #1 was placed in a wheelchair and attempted to propel the wheelchair with their arms. Two staff members held onto Resident #1's arms and the resident placed their feet down. Two additional staff members held onto the resident's legs. Resident #1 was brought back to their room via the wheelchair with staff members holding onto each limb. Resident #1 was transported to the hospital via ambulance a short time later. Resident #1 returned to the facility at 2:00 PM on 3/15/2025. The root cause analysis documented that according to statements obtained from staff, several attempts were made to keep Resident #1 safe (after they had received Haldol injection ordered by the medical provider), including assisting them to a wheelchair for transport back to their room. The investigation summary initiated on 3/18/2025 provided to surveyors during the onsite survey, did not include a conclusion.</p> <p>Review of a psychiatric diagnosis evaluation dated 3/20/2025 documented Resident #1 felt traumatized by their recent conflict with staff.</p> <p>Review of the investigative summary submitted to the New York State Department of Health on 3/21/2025 at 1:26 PM documented Resident #1 did share with their family representatives that they were forcibly placed in a wheelchair and restrained after the incident occurred. Resident #1 has noted on several occasions since the incident that they were restrained by a group of people.</p> <p>During an interview on 3/28/2025 at 11:10 PM, the Security Officer #1 stated they work the overnight shift in the facility. The Security Officer #1 stated Resident #1 was acting out of character and refused to put their pants on. The Security Officer #1 stated they went up to the unit to talk to Resident #1 to see if they would put their clothes on and Resident #1 refused, so they left the resident alone. The Security Officer #1 denied touching Resident #1 on 3/15/2025 during the incident. They stated the staff forced Resident #1 into the wheelchair and escorted the resident back to their unit. The Security Officer #1 stated Resident #1 was trying to stop the staff by grabbing the wheelchair and placing their feet under the wheelchair, but the staff held the resident back in the wheelchair. The Security Officer #1 stated three (3) to four (4) staff members held Resident #1's legs, to prevent the resident from sticking their legs under the wheelchair, and they held the resident back into the wheelchair. The Security Officer #1 stated they do not know why the staff continued to push Resident #1 into the wheelchair.</p> <p>During an interview on 3/26/2025 at 11:30 AM Resident #1 stated about two weeks ago there was an incident, but they do not want to comment on th incident and that there was an incident report on file regarding the incident. Resident #1 stated they felt safe in the facility as long as they had the one on one monitoring. The Surveyors asked Resident #1 if they were afraid of retaliation and they stated they were not afraid of anyone in the facility. Resident #1 stated they would like the surveyors to call their family representative for an account of what happened. Resident #1 stated they had a bruise from the incident but would not allow surveyors to look at the bruise when asked.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/2025 at 12:35 PM the Administrator stated Resident #1's representative sent an email to the Admissions Director on 3/16/2025, stating they wanted to review the surveillance video footage. The Administrator stated they received the email the morning of 3/17/2025, where Resident #1's representative wrote that Resident #1 was assaulted. The Administrator stated they spoke about the email during the morning meeting on 3/17/2025 at 9 AM. Staff reported Resident #1 had three behavioral episodes including the morning of the incident but there was no mention of the interventions that applied by staff during the incident. The Administrator stated Registered Nurse #2 was contacted to determine what time the incident occurred and the location in order to review the surveillance camera footage. The Administrator stated they did not hear back from Registered Nurse #2 until 8pm on 3/17/2025 and they reviewed the surveillance video footage on 3/18/2025 between 9 AM and 10 AM. The Administrator stated they felt by the time the staff intervened physically, Resident #1 appeared to be calm, and staff should have left the resident and not even attempted to administer the medications. The Administrator stated they would have let Resident #1 be and ensured everyone was safe.</p> <p>During an interview on 3/27/2025 at 9:27 AM Certified Nurse Assistant #2 stated Resident #1 sat in a chair and they could not get them to get up and the nurse then called for the resident to get some medication. Certified Nurse Assistant #2 stated after the medication Resident #1 was still disruptive and the staff did not leave Resident #1 there because they did not belong on that unit. Certified Nurse Assistant #2 stated Resident #1 did not willing take the medication and they held the resident's hands down. Certified Nurse Aide #2 stated that together with Registered Nurse #2, the Security Officer #1, Registered Nurse #1, and possibly Licensed Practical Nurse #2, they placed Resident #1 in a wheelchair on the day of the incident. Because the resident was fussing and kicking, they each took a limb, and they brought Resident #1 back to their unit and put the resident in bed. They wanted to protect other residents</p> <p>During a telephone interview on 3/27/2025 at 10:07 AM, Resident #1's representative stated on 3/15/2025 they got a phone call from Resident #1 stating they were assaulted and were at the hospital. Resident #1's representative stated Resident #1 stated their leg was bleeding and that the staff had restrained them. Resident #1's representative stated Resident #1 stated they were in another resident's room, because they were trying to get away from the staff. Resident #1's representative stated Resident #1 reported the staff were trying to kick their legs so that they would sit down in the wheelchair. Resident #1's representative stated they have been trying to get a copy of the incident reports, and the facility would not provide them nor be transparent with them. Resident #1's representative stated Resident #1 informed them of the staff involved in the incident and described a restraint situation at one point.</p> <p>During an interview on 3/27/2025 at 10:47 AM the Director of Nursing stated they reviewed the surveillance camera footage and saw the staff sat Resident #1 down in the wheelchair. The Director of Nursing stated once they sat Resident #1 in the wheelchair the resident began to resist, so the staff took their hands off the wheelchair, and then the resident started to kick. The Director of Nursing stated the staff should have left Resident #1 alone and assigned someone to observe them. The staff should have allowed Resident #1 to leave the unit and just had someone stay with them.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/2025 at 1:05 PM Licensed Practical Nurse #1 stated the Security Officer had the wheelchair sitting behind Resident #1 and they could not remember if the resident was willing and sat in the wheelchair. Licensed Practical Nurse #1 stated Resident #1 continued to kick and fight while in the wheelchair and was been pushed too their room. Licensed Practical Nurse #1 stated to get Resident #1 to stay in the wheelchair they lifted the resident's legs and arms. Licensed Practical Nurse #1 stated Certified Nurse Assistant #2, Registered Nurse #2 and the Security Officer #1 were present and the staff took Resident #1 back to their unit to their room.</p> <p>During an interview on 3/28/2025 at 1:22 PM, Registered Nurse #2 stated they recall assisting Resident #1 into a wheelchair with other staff including the Security Officer, Certified Nurse Aide #2 and Licensed Practical Nurse #1 on the day of the incident. They wanted to move Resident #1 to their room so the resident could be safe. Registered Nurse #2 stated they were on Resident #1's left side holding their left leg, Certified Nurse Aide #2 was also on the residents left side and Licensed Practical Nurse #1 assisted as well. Registered Nurse #2 stated Resident #1 was aggressive, and that is why they moved the resident back to their unit. The surveyor asked Registered Nurse #2 several times what threat Resident #1 was posing, and they continued to respond they just wanted the resident to be safe.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews during an abbreviated survey (NY00375411), the facility did not ensure that a resident is free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms for one (1) of three (3) residents (Resident #1) reviewed for restraints. Specifically, on 3/15/2025 Resident #1 was seen on Facility Surveillance Camera Footage wandering the hallway to the adjacent unit. Resident #1 was seen going in and out of other resident's rooms. Security Officer #1 was observed grabbing Resident #1 by their wrist to keep the resident in one place. Resident #1 is observed on surveillance camera footage in a wheelchair and trying to propel themselves away from the staff. Resident #1 was seen with all four of their extremities held by four staff members (Certified Nurse Aide #2, the Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2), preventing the resident's movement. Staff was seen wheeling the resident back to their room holding on to all four extremities. This resulted in psychosocial harm to Resident #1 and the potential for serious injury that is not immediate jeopardy.</p> <p>The findings are:</p> <p>The Facility Restraints-Use of Chemical or Physical Restraints last revised 9/2023 documented the facility shall provide its residents with considerate and respectful care designed to promote the resident's independence, dignity and safety in the least restrictive environment commensurate with resident's preference, physical and mental status. The facility is generally a restraint free facility. The purpose is to ensure resident's safety and maintain optimum levels of physical and emotional functioning when in restraints. Physical or chemical restraints are not used at the facility.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including but not limited to Parkinsonism (brain condition that causes slow movement, tremors, rigidity), anxiety disorder and Depression.</p> <p>An Admission Minimum Data Set, dated dated dated [DATE] documented Resident #1 was cognitively intact.</p> <p>Review of a psychosocial well-being care plan dated 3/13/2025 documented Resident #1's well-being as positively able to verbalize needs, engages in conversation with others, and has a supportive family who visits. Resident #1 is negatively impacted by increase in confusion, sundowning (a collection of behaviors such as difficulty sleeping, anxiety, agitation, and restlessness that occurs from dusk through night), and declining health status. Interventions listed included to monitor effectiveness of approaches, provide support and show interest in well-being through verbalization and supportive techniques, identify conflicts and apply appropriate approaches for resolution. No specific approaches were documented on the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a mood care plan dated 3/13/2025 documented Resident #1 had potential for mood issues related to diagnoses of anxiety, sundowning (a collection of behaviors such as difficulty sleeping, anxiety, agitation and restlessness) that occurs from dusk through night) and Parkinson's disease. Resident #1 expressed feeling down, depressed or hopeless, feeling tired or having little energy, poor appetite and having trouble falling asleep or staying asleep, or sleeping too much. Interventions listed included assess and monitor resident to determine onset of mood problem, assist resident in managing feelings by having staff available during upset episodes, encourage to verbalize concerns, try to get resident to identify unmet needs, do not negate residents' feelings and let it be known that efforts will be made to relieve anxieties and concerns. Acknowledge difficulty adjusting to facility, establish foundation for trust and support and involve significant individuals in life as support while dealing with mood issues.</p> <p>Review of the Facility Surveillance Camera Recording dated 3/15/2025 revealed at 5:42 AM Resident #1 was standing in the hallway of the unit, wearing a T-shirt, briefs and tennis shoes. At 5:50 AM Resident #1 is seen wandering around the unit and enters another resident's room. Registered Nurse #1 is observed trying to redirect Resident #1. At 5:51 AM Security Officer #1 is seen in the hallway grabbing Resident #1 by both wrists and attempting to keep Resident #1 in one place. Registered Nurse #2 is seen witnessing the incident. At 5:52 AM Resident #1 broke free from Security Officer #1 and walked down the hallway. Security Officer #1 and Registered Nurse #2 are seen following the resident. At 6:03 AM Resident #1 is seen getting up from a chair and walking down the hallway with Registered Nurse #2 walking closely behind. Resident #1 continues to wander the hallway to another unit. Registered Nurse #2 is seen trying to redirect the resident. At 6:07 AM Certified Nurse Aide #2, Licensed Practical Nurse #1, Security Officer #1 and Registered Nurse #2 show up with a wheelchair and they were seen trying to get Resident #1 to sit down in the wheelchair. At 6:09 AM Resident #1 was seen wandering the hallway with Registered Nurse #2, Security Officer #1 and Certified Nurse Aide #2 following behind. Resident #1 sat in a recliner in the common area. Security Officer #1 and Certified Nurse Aide #1 are seen standing in front of the seated resident. At 6:11 AM Registered Nurse #1 was seen attempting to administer oral medication to Resident #1, which they refused. At 6:13 AM Licensed Practical Nurse #2 tries to administer the oral medication, and the resident appears to swing at Licensed Practical Nurse #2. Between 6:13 AM and 6:19 AM, Certified Nurse Aide #2 and Security Officer #1 are observed standing in the common area with Resident #1. Between 6:21 AM and 6:23 AM, Certified Nurse Aide #2 leaves and Resident #1 stands from the chair and sits back down. At 6:26 AM, Resident #1 gets up from the chair and Security Officer #1 was attempting to stop the resident by blocking their path with a wheelchair. At 6:27 AM four (4) staff members (Certified Nurse Aide #2, Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2) were observed assisting with sitting Resident #1 in a wheelchair. Resident #1 attempts to propel the wheelchair with their hands and legs and Certified Nurse Aide #2, Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2 each grab Resident #1 by their extremities. Resident #1 is then seen swinging their arms and attempting to get free from the restraint of the staff members. Resident #1 is seen kicking at Registered Nurse #1 and attempted to remove Security Officer #1's hand from their wrist. Resident #1 continues to kick and attempt to remove the staffs' hold of their arms. At 6:27 AM Licensed Practical Nurse #1 is seen holding Resident #1 by the left arm, Registered Nurse #2 is standing to the right of the resident, Certified Nurse Aide #2 is standing behind the resident putting on gloves. Licensed Practical Nurse #1 proceeds to grab both of Resident #1's wrist, while holding the resident against the wall in the hallway. Certified Nurse Aide #2 and Registered Nurse #2 proceed to grab Resident #1's right arm and Registered Nurse #1 is seen administering an injection to Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>At 6:29 AM Certified Nurse Aide #2, Security Officer #1, Licensed Practical Nurse #1 and Registered Nurse #2 are seen moving Resident #1 down the hall while physically restraining the resident's extremities. Registered Nurse #1 is seen following behind. Resident #1 was brought back to the unit and into the resident's room.</p> <p>Review of an undated Facility Incident Report submitted on 3/18/2025 at 12:30 PM documented the incident occurred on 3/15/2025 at 6:27 AM and the Administrator was made aware of the incident on 3/18/2025 at 10:00 AM. Resident #1 was walking around their unit in a shirt and brief on 3/15/2025 at approximately 5:43 AM. Resident #1 was not able to be re-directed by the nurse and entered another resident's room. Security and the supervisor were called for assistance. Resident #1 went to the adjoining unit and entered at least two other resident's rooms. At some point Resident #1 attempted to close the door of another resident's room on the supervisor's arm. Orders were received for oral Ativan and Haldol intramuscularly. Resident #1 spit out the oral Ativan and the Haldol was administered intramuscularly. Resident #1 was placed in a wheelchair and attempted to propel the wheelchair with their arms. Two staff members held onto Resident #1's arms and the resident placed their feet down. Two additional staff members held onto the resident's legs. Resident #1 was brought back to their room via the wheelchair with staff members holding onto each limb. Resident #1 was transported to the hospital via ambulance a short time later. Resident #1 returned to the facility at 2:00 PM on 3/15/2025. The root cause analysis documented that according to statements obtained from staff, several attempts were made to keep Resident #1 safe (after they had received Haldol injection ordered by the medical provider), including assisting them to a wheelchair for transport back to their room. The investigation summary initiated on 3/18/2025 provided to surveyors during the onsite survey, did not include a conclusion.</p> <p>Review of the facility investigative summary submitted to the New York State Department of Health on 3/21/2025 at 1:26 PM documented Resident #1 shared with their family, after the incident, that they were forcibly placed in a wheelchair and restrained. The summary documented that Resident #1 has noted on several occasions since the incident that they were restrained by a group of people. Resident #1 was moved to a private room two days after the incident. Medication adjustments were made with collaboration with Resident #1's neurologist.</p> <p>During an interview on 3/26/2025 at 12:35 PM, the Administrator stated they felt by the time the staff intervened physically, Resident #1 appeared to be calm, and staff should have left the resident and not even attempted to administer the medications. The Administrator stated they would have let Resident #1 be and ensured everyone was safe.</p> <p>During an interview on 3/27/2025 at 9:27 AM, Certified Nurse Aide #2 stated that together with Registered Nurse #2, the Security Officer #1, Registered Nurse #1, and possibly Licensed Practical Nurse #2, they placed Resident #1 in a wheelchair on the day of the incident. Because the resident was fussing and kicking, they each took a limb, and they brought Resident #1 back to their unit and put the resident in bed. Certified Nurse Aide #2 stated as the staff were placing Resident #1 in the bed, the resident kicked Licensed Practical Nurse #1 on the side.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER New York State Veterans Home at Montrose		STREET ADDRESS, CITY, STATE, ZIP CODE 2090 Albany Post Road Montrose, NY 10548	
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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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/27/2025 at 10:34 AM, Attending Physician #1 stated they received a call from the facility on 3/15/2024 at around 5:00 AM informing them that there was a new admission who was agitated, paranoid and felt staff were trying to hurt them. Attending Physician #1 stated it was reported to them that Resident #1 was going in and out of other resident's rooms and was being physically combative with staff. Attending Physician #1 stated they did not have the opportunity to view the surveillance camera footage of what took place on 3/15/2025. Attending Physician#1 stated they gave orders for Ativan by mouth and Haldol intramuscularly.</p> <p>During an interview on 3/28/2025 at 11:10 PM, the Security Officer #1 denied touching Resident #1 on 3/15/2025 during the incident. They stated the staff forced Resident #1 into the wheelchair and escorted the resident back to their unit. The Security Officer #1 stated Resident #1 was trying to stop the staff by grabbing the wheelchair and placing their feet under the wheelchair, but the staff held the resident back in the wheelchair. The Security Officer #1 stated three (3) to four (4) staff members held Resident #1's legs, to prevent the resident from sticking their legs under the wheelchair, and they held the resident back into the wheelchair. The Security Officer #1 stated they do not know why the staff continued to push Resident #1 into the wheelchair.</p> <p>During an interview on 3/28/2025 at 1:05 PM, Licensed Practical Nurse #1 stated when they arrived at the facility on 3/15/2025 at 6:30 AM, Registered Nurse #2 and Registered Nurse #1 (they cannot remember their name) were talking about Resident #1 being aggressive. Licensed Practical Nurse #1 stated Registered Nurse #2 told the nurse to call Attending Physician #1 and they heard them say Resident #1 needed an injection of Haldol. Licensed Practical Nurse #1 stated they were there waiting to start their shift when the nurse got the order, and they were asked to give support. Licensed Practical Nurse #1 stated they walked from Resident #1's unit to the other unit and when they got to the unit they saw Resident #1 walking with no assistive device. Licensed Practical Nurse #1 stated Resident #1 asked how they were, and they placed their self-next to the resident, to make sure the resident did not fall. Licensed Practical Nurse #1 stated they were trying to get Resident #1 to go back to their unit and the resident stated the staff were trying to kill them. Licensed Practical Nurse #1 stated they asked Resident #1 to come with them and they refused. Licensed Practical Nurse #1 stated they cannot recall if anyone was holding Resident #1 or not during the injection of the Haldol, but after the injection the resident kept trying to hit them with a sharpie marker they had in their hand, so they took the marker from Resident #1, and the resident was hitting them in the arm. Licensed Practical Nurse #1 stated the staff wanted to get Resident #1 in the wheelchair because they did not know how the resident would react to the injection.</p> <p>During an interview on 3/28/2025 at 1:22 PM, Registered Nurse #2 stated they recall assisting Resident #1 into a wheelchair with other staff including the Security Officer, Certified Nurse Aide #2 and Licensed Practical Nurse #1 on the day of the incident. They wanted to move Resident #1 to their room so the resident could be safe. Registered Nurse #2 stated they were on Resident #1's left side holding their left leg, Certified Nurse Aide #2 was also on the residents left side and Licensed Practical Nurse #1 assisted as well. Registered Nurse #2 stated Resident #1 was aggressive, and that is why they moved the resident back to their unit.</p> <p>10 NYCRR 415.4(a)(2-7)</p>		

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<p>F 0605</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews during an abbreviated survey (NY00375411) the facility did not ensure that the resident was free from chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for one (1) out of three (3) residents (Resident #1) reviewed for restraints. Specifically, on 3/15/2025 the facility staff administered intramuscular anti-psychotic medication to Resident #1. Resident #1 was seen on a surveillance camera wandering on the unit and going in and out of other resident's rooms. Resident #1 was observed on surveillance camera being held against the wall by four (4) staff members (Certified Nurse Aide #2, Licensed Practical Nurse #1, Security Officer #1 and Registered Nurse #2) and administered the intramuscular injection. Resident #1's medication list did not include any anti-psychotics on admission. In addition, Resident #1 had no documented medical symptom or appropriate assessment for the use of the antipsychotic medication. This resulted in the use of a chemical restraint to subdue the resident which had the potential for serious harm/injury that is not immediate jeopardy</p> <p>The findings are:</p> <p>The Facility Restraints-Use of Chemical or Physical Restraints policy last revised 9/2023 documented the facility shall provide its residents with considerate and respectful care designed to promote the resident's independence, dignity and safety in the least restrictive environment commensurate with resident's preference, physical and mental status. The facility is generally a restraint free facility. The purpose is to ensure resident's safety and maintain optimum levels of physical and emotional functioning when in restraints. Physical or chemical restraints are not used at the facility.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including but not limited to Parkinsonism (brain conditions that cause slowed movements, rigidity (stiffness) and tremors), anxiety disorder, and Depression(mood disorder that causes persistent feeling of sadness and loss of interest in things and activities once enjoyed) .</p> <p>An Admission Minimum Data Set, dated dated dated [DATE] documented Resident #1 was cognitively intact.</p> <p>Review of a psychosocial well-being care plan dated 3/13/2025 documented Resident #1's well-being as positively able to verbalize needs, engages in conversation with others, and has a supportive family who visits. Resident #1 is negatively impacted by increase in confusion, sundowning (a collection of behaviors such as difficulty sleeping, anxiety, agitation, and restlessness that occurs from dusk through night), and declining health status. Interventions listed included to monitor effectiveness of approaches, provide support and show interest in well-being through verbalization and supportive techniques, identify conflicts and apply appropriate approaches for resolution.</p> <p>There was no documented evidence of any specific approaches documented on the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a mood care plan dated 3/13/2025 documented Resident #1 had potential for mood issues related to diagnoses of anxiety, sundowning and Parkinson's disease. Resident #1 expressed feeling down, depressed or hopeless, feeling tired or having little energy, poor appetite and having trouble falling asleep or staying asleep, or sleeping too much. Interventions listed included assess and monitor resident to determine onset of mood problem, assist resident in managing feelings by having staff available during upset episodes, encourage to verbalize concerns, try to get resident to identify unmet needs, do not negate residents' feelings and let it be known that efforts will be made to relieve anxieties and concerns. Acknowledge difficulty adjusting to facility, establish foundation for trust and support and involve significant individuals in life as support while dealing with mood issues.</p> <p>Review of the Facility Surveillance Camera Recording dated 3/15/2025 revealed at 5:42 AM Resident #1 is observed standing in the hallway of the unit, wearing a T-shirt, briefs and tennis shoes. At 5:50 AM Resident #1 is seen wandering around the unit and enters another resident's room. Registered Nurse #1 is observed trying to redirect Resident #1. Resident #1 comes out of the room, goes to the nursing cart and began writing on a piece of paper. Registered Nurse #1 attempted to grab Resident #1's wrist and then quickly let go and began removing items off the top of the nursing cart. At 6:09 AM Resident #1 was seen wandering the hallway with staff following behind. Resident #1 sat in a recliner in the common area. At 6:11AM Registered Nurse #1 and Certified Nurse Aide #3 enter the common area attempting to administer some oral medication to Resident #1. The resident refuses. At 6:13 AM Licensed Practical Nurse #2 was seen attempting to give Resident #1 some oral medication, and the resident swung their hand at Licensed Practical Nurse #2 and Licensed Practical Nurse #2 handed the medication back to Registered Nurse #1. At 6:27 AM Licensed Practical Nurse #1 is seen holding Resident #1 by the left arm, Registered Nurse #2 is standing to the right of the resident, Certified Nurse Aide #2 is standing behind the resident putting on gloves. Licensed Practical Nurse #1 proceeds to grab both of Resident #1's wrist, while holding the resident against the wall in the hallway. Certified Nurse Aide #2 and Registered Nurse #2 proceed to grab Resident #1's right arm and Registered Nurse #1 is seen administering an injection to Resident #1.</p> <p>During an interview on 3/26/2025 at 12:35 PM, the Administrator stated they felt by the time the staff intervened physically, Resident #1 appeared to be calm, and staff should have left the resident and not attempted to administer the medications. The Administrator stated they would have let Resident #1 be and ensured everyone was safe.</p> <p>During an interview on 3/27/2025 at 9:27 AM, Certified Nurse Aide #2 stated Resident #1 sat in a chair in the common area, and they refused to get up. Registered Nurse #1 then called for the resident to get some medication. Certified Nurse Aide #2 stated after the medication Resident #1 was still disruptive and the staff brought Resident #1 back to their own unit.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/27/2025 at 10:34 AM, Attending Physician #1 stated they received a call from the facility on 3/15/2024 at around 5:00 AM informing them there was a new admission who was agitated, paranoid and felt staff were trying to hurt them. Attending Physician #1 stated it was reported to them that Resident #1 was going in and out of other resident's rooms and was being physically combative with staff. Attending Physician #1 stated they were called multiple times, and they first recommended that Resident #1 be give oral Ativan (sedative). Attending Physician #1 stated they were then informed that Resident #1 spit the medication out and was still agitated and paranoid, so they ordered intramuscular Haldol (antipsychotic) to be administered. Attending Physician #1 stated following the administration of the Haldol Resident #1 was still reportedly agitated, so they ordered to send the resident out to the hospital for further evaluation. Attending Physician #1 stated Haldol and Ativan are the only two behavioral drugs available on hand at the facility. Attending Physician #1 stated if Resident #1 was only being verbally aggressive or in distress, they would have recommended other interventions such as placing the resident on a one-to-one monitoring or redirection should be attempted first. Attending Physician #1 stated that it was explained to them that other interventions were tried and did not work. Attending Physician #1 stated they did not have the opportunity to view the surveillance camera footage of what took place on 3/15/2025.</p> <p>During an interview on 3/28/2025 at 11:10 PM, Security Officer #1 stated the nurses tried to give Resident #1 some medication and the resident knocked it out of the nurse's hand. Security Officer #1 stated the nurses gave Resident #1 an injection while the staff were holding the resident so the injection could be administered.</p> <p>During an interview on 3/28/2025 at 1:05 PM Licensed Practical Nurse #1 stated when they arrived at the facility on 3/15/2025 at 6:30 AM, Registered Nurse #2 and another nurse (unable to recall name of nurse) were talking about Resident #1 being aggressive. Licensed Practical Nurse #1 stated Registered Nurse #2 asked Registered Nurse #1 to call Attending Physician #1 and they heard Registered Nurse #2 say that the resident needed an injection of Haldol. Licensed Practical Nurse #1 stated the staff were trying to get Resident #1 in the wheelchair before administering the injection because they were not sure how the resident would react to the injection.</p> <p>During an interview on 3/28/2025 at 1:22 PM, Registered Nurse #2 stated during the incident, Resident #1 entered another resident's room, the other resident was awake and asked Resident #1 to leave their room. Resident #1 tried to close the door while in the room, and Registered Nurse #2 tried to keep the door open. Registered Nurse #2 stated after a few minutes Resident #1 came out of the room. They asked Registered Nurse #1 to check the orders for Resident #1 to see if they had any as needed medication orders for the resident, as they were a new admission. Registered Nurse #2 stated Registered Nurse #1 checked the orders for Resident #1 and saw there was an as needed order for oral Ativan. Registered Nurse #2 stated Resident #1 was wandering around the unit at that time and raising their fists. Registered Nurse #1 gave the resident the oral medication and they spit it out, so Registered Nurse #1 called Attending Physician #1 (who was on call) and got an order for intramuscular Haldol. Registered Nurse #2 stated Resident #1 was still on the adjacent unit going into other resident's rooms. Registered Nurse #2 stated Registered Nurse #1 then came and administered the Haldol injection, but they do not recall how the injection was given. All they could remember was that Resident #1 was standing up fighting and resisting Registered Nurse #1 from giving the injection.</p> <p>10 NYCRR 415.4(a)(1) and 415.3(d)(1)(vii)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372</p> <p>Based on record review and interviews during an abbreviated survey (NY00375411) , the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 24 hours if the events that cause the allegation do not result in serious bodily injury, to the administrator of the facility for 1 out of 3 residents (Resident #1) reviewed for abuse. Specifically, on 3/17/2025 Resident #1's representative emailed the facility and informed them Resident #1 stated they were assaulted by staff on 3/15/2025 and requested to view the surveillance camera footage. The Administrator was not informed of the alleged incident that occurred on 3/15/2025 until 3/17/2025. The Administrator reviewed the video surveillance footage on 3/18/2025 and the incident was reported to the New York State Department of Health on 3/18/2025.</p> <p>The findings are:</p> <p>The facility Abuse Prohibition policy last revised 9/2023 documented the home shall prohibit abuse through the following: training of employees (new employees and ongoing training of all employees), identification of possible incidents or allegations which need investigation, investigation of incidents and allegations and reporting of incidents, investigations as well as the home's response to the results of the investigations. When dealing with situations where abuse is alleged to have occurred any person who has reasonable cause to believe that any situation of resident abuse has occurred is responsible to immediately notify his/her supervisor, circumstances to be reported may include, but are not limited to, a statement that physical abuse has occurred, the supervisor is to immediately notify the Administrator/designee, the supervisor will complete the appropriate form (Accident/Incident Report form, Investigation Form, Abuse Allegation Investigation Form) and initiate the investigation.</p> <p>Resident #1 admitted to the facility with diagnoses including but not limited to Parkinsonism, Anxiety Disorder and Depression.</p> <p>An Admission Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact. The resident exhibited physical and verbal behaviors the significantly interfere with the resident's care and impact others. The resident required a walker and a wheelchair for locomotion. The resident set up assistance with eating and bed mobility, moderate assistance with toileting and independent with transfers. The resident was occasionally incontinent with urine and frequently incontinent of bowels. The resident was on as needed antipsychotic.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility Incident Report submitted to the New York State Department of Health on 3/18/2025 at 12:30 PM documented the incident occurred on 3/15/2025 at 6:27 AM and the Administrator was made aware on 3/17/2025 via email and reviewed the video surveillance on 3/18/2025 at 10:00 AM. Resident #1 was walking around their unit in a shirt and brief on 3/15/2025 at approximately 5:43 AM. Resident #1 was not able to be re-directed by the nurse and entered another resident's room. Security and the supervisor were called for assistance. Resident #1 went to the adjoining unit and entered at least two other resident's rooms. At one point Resident #1 attempted to close the door of another resident's room on the supervisor's arm. Orders were received for oral Ativan and Haldol intramuscularly. Resident #1 spit out the oral Ativan and the Haldol intramuscularly was administered. Resident #1 was placed in the wheelchair and was attempting to propel the wheelchair with their arms. Two staff members held onto Resident #1's arms and the resident then put their feet down. Two additional staff members held onto the residents' legs. Resident #1 was transported back to their room via the wheelchair with staff members holding onto each limb. Resident #1 was transferred to the hospital via ambulance a short time later. Resident #1 returned to the facility before 2 PM on 3/15/2025.</p> <p>During an interview on 3/26/2025 at 12:35 PM, the Administrator stated Resident #1's representative sent an email to the Admissions Director, the night of 3/16/2025, stating they wanted to review the surveillance video footage. The Administrator stated they received the email the morning of the 3/17/2025, with Resident #1's representative stating Resident #1 was assaulted. The Administrator stated they spoke about the email received during the morning meeting on 3/17/2025 at 9 AM. The Administrator stated the incident was reported as Resident #1 having three behavioral episodes including the morning of the incident. There was no mention of the physical interventions applied by staff. Registered Nurse #2 was contacted so they would know what time the incident occurred and the location in order to view on the surveillance camera footage. The Administrator stated Registered Nurse #2 did not call back until 8 PM on 3/17/2025. The review of the surveillance video footage was done on 3/18/2025 between 9 AM and 10 AM. The Administrator stated they were labeling the situation as a behavior and did not label it as an incident. The Administrator stated the proper protocol would be for the supervisor to reach out to the Director of Nursing immediately. They do not know why the supervisor did not report the incident to the Director of Nursing immediately. The Administrator stated they did not initiate the investigation and report to the New York State Department of Health because they were informed Resident #1 had behaviors. The Administrator stated they could have initiated the report, but they did not because the information provided at the meeting was related to Resident #1's behaviors.</p> <p>During an interview on 3/27/2025 at 10:47 AM, the Director of Nursing stated they found out about the incident that occurred on 3/15/2025, during the morning meeting on 3/17/2025. The Director of Nursing stated the Administrator informed them that an email was forwarded from Resident #1's representative stating Resident #1 informed their representative that they were restrained by staff. The Director of Nursing stated they were asked by the Administrator to find out where the incident occurred and who was involved. The Director of Nursing stated they started the investigation by talking to the day supervisor, who informed them the incident occurred on the night shift over the weekend. The Director of Nursing stated they called Registered Nurse #2 throughout the day on 3/17/2025 and did not get a response. Since they could not contact Registered Nurse #2, they sent them a text message and email. The Director of Nursing stated later that night on their way home, they received a call from Registered Nurse #2. The Director of Nursing stated the Administrator wanted to view the surveillance camera footage to determine what happened.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/2025 at 1:22 PM, Registered Nurse #2 stated they did not complete an incident report because they felt it was just a behavior and they gave report to the oncoming nurse about the situation but did not report this to any of the administrative staff. Registered Nurse #2 stated they were trained to report falls with injury, neglect, abuse or anything that they would need more assistance with.</p> <p>10NYCRR 415.4(b)(1)(ii)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50815</p> <p>Based on record review and interviews during the abbreviated survey (NY00365964), the facility did not ensure that all allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 1 of 3 residents (Resident #3) reviewed for abuse. Specifically, Resident # 3 sustained a skin tear to left hand on 12/17/2024 that was not thoroughly investigated by the facility.</p> <p>Findings include:</p> <p>The Facility Abuse Prohibition policy last revised 9/2023 documented the home shall prohibit abuse through the following: training of employees (new employees and ongoing training of all employees), identification of possible incidents or allegations which need investigation, investigation of incidents and allegations and reporting of incidents, investigations as well as the home's response to the results of the investigations. When dealing with situations where abuse is alleged to have occurred any person who has reasonable cause to believe that any situation of resident abuse has occurred is responsible to immediately notify his/her supervisor, circumstances to be reported may include, but are not limited to, a statement that physical abuse has occurred, the supervisor is to immediately notify the Administrator/designee, the supervisor will complete the appropriate form (Accident/Incident Report form, Investigation Form, Abuse Allegation Investigation Form) and initiate the investigation.</p> <p>Resident # 3 was admitted to the facility with diagnosis that included but not limited to Dementia, Atrial Fibrillation, Congestive Heart Failure, and Muscle Wasting.</p> <p>An admission Minimum Data Set, dated dated [DATE] documented Brief interview of Mental Status score of 4 with physical behavior symptoms directed towards others, and wandering. The resident has no impairment on upper and lower extremities, uses a walker and wheelchair for locomotion, requires set up or clean up assistance for eating, independent with bed mobility and transfers, occasionally incontinent of bladder and always continent of bowel.</p> <p>A review of a nursing progress note dated 12/17/2024 at 6:34pm documented open purpura to left hand. Skin tear protocol in place. No c/o pain.</p> <p>A review of the medical progress note dated 12/19/2024 documented that on 12/18/2024 the resident was seen for follow up on recent admission with dementia, agitation, wandering, confusion. Noted with insomnia, wandering on the unit, exiting on the unit, exit seeking. Non-compliant and with physical aggression to staff. Resident medical history reviewed. Medications list reviewed. Skin: No rash</p> <p>A review of the medical progress notes dated 12/20/2024 documented seen for follow up of left-hand ecchymosis on exam. Ecchymosis present at base of 1st and 2nd fingers. Skin tear with scab present, normal range of motion of fingers, wrist. No tenderness of digits, wrist or hands. No further treatment needed.</p> <p>There was no documented evidence of any incident report or any skin assessment or any resident refusals pertaining to the resident's skin tear on 12/17/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER New York State Veterans Home at Montrose		STREET ADDRESS, CITY, STATE, ZIP CODE 2090 Albany Post Road Montrose, NY 10548	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/2025 at 11:41am, the Assistant Administrator stated they do not have an incident report on Resident # 3 because they were only in the facility for a week, and there were no skin assessments completed for the resident pertaining to the incident on 12/17/2024.</p> <p>During an interview on 3/28/2025 at 2:24 PM, Licensed Practical Nurse #3 stated Resident # 3 wanted to go home after their admission. The resident went to the main door of the unit and the Certified Nursing assistant # 4 told them that the resident hit them with their walker and the resident was bleeding from the purpura opening. Licensed Practical Nurse #3 treated the resident's hand, initiated the skin protocol order, and documented a behavior note in the residents electronic medical record. Licensed Practical Nurse #3 could not recall if the physician was notified, but they stated the called the resident's family member. Licensed Practical Nurse #3 stated it was brought to their attention that they did not write a note that they contacted the family; therefore, there made a late entry note after the resident was discharged .</p> <p>During an interview on 3/28/2025 at 2:32 PM, Social Worker # 1 stated Resident # 3 had an incident that was reported during the morning meeting on 12/18/2024. The report was that the resident was wandering out of the unit and the staff followed him and the resident hit the staff with the walker. Social Worker #1 stated Resident #3's family representative informed them that Resident # 3 had a mark on their hand. Social Worker # 1 stated they went to see Resident # 3, and they saw a scar on the resident's hand but Resident # 3 Family Representative wanted to take the resident home because they alleged that someone hit the resident. Social Worker # 1 stated they reported the allegation to the Director of Nursing and the Administrator. Resident #3's Family Representative took the resident out of the facility Against Medical Advice but refused to sign the form.</p> <p>During an interview on 3/28/2025 at 3:09 PM, the Director of Nursing stated there should not have been an incident report for the resident because the incident was observed and the skin tear was over purpura, and the purpura was opened because it was hit by the walker. Director of Nursing stated Resident # 3 refused to have a skin assessment upon admission and multiple attempts were made but they refused. The refusals and ongoing attempts to complete a skin assessment should have been documented in a nursing progress note. If the resident was found with an unwitnessed skin tear, then they would do an incident report. Director of Nursing reviewed the Nursing Progress notes and acknowledged that they do not see anything in the notes documenting a skin assessment was refused. Director of Nursing stated at that time Resident #3's Family Representative was informed that the facility tried to contact her regarding the incident. Resident # 3 Family Representative was upset that they were not notified and stated that they would be taking Resident # 3 home. Against Medical Advice. Family representative was informed Resident # 3 had a behavior of smashing his walker on the floor and at people/thing</p> <p>During a telephone interview on 4/2/2025 at 3:30pm, Resident # 3's Family Representative stated they went to visit their family on 12/19/2024 and heard a story about how Resident # 3 attempted to leave out of a door. The nurse tried to stop their family member from leaving and it was reported that the resident was injured. Resident # 3's Family Representative stated the facility did not attempt to call them when the incident occurred. Resident # 3 Family Representative stated they requested for the facility to show them the incident report, but the facility denied this request on 12/19/2024. Resident # 3's Family Representative stated they thought someone may have abused the resident and brought it to the facility's attention. They decided to take Resident # 3 out of the facility because they were injured. The facility asked them to sign an Against Medical Advice form, and they refused to sign.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER New York State Veterans Home at Montrose		STREET ADDRESS, CITY, STATE, ZIP CODE 2090 Albany Post Road Montrose, NY 10548	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 483.12(c)