| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335832 | A. Building<br>B. Wing | 06/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| New York State Veterans Home at Montrose | 2090 Albany Post Road<br>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) |
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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 record review and interviews conducted during the Recertification and Abbreviated Survey NY 00331181 from 5/28/25 to 6/4/25 the facility did not ensure residents received adequate supervision to prevent accidents for one (1) of four (4) residents (Resident #254) reviewed for accidents. Specifically, a two (2) person assist during transfers was not provided as per care plan which resulted in Resident # 254 sustaining two (2) skin tears to their right upper arm and a 1 cm by 1 cm abrasion to their head.<br><br>The findings include:<br><br>Resident #254 was admitted to the facility with diagnoses including Parkinson's Disease, Anxiety, and Vascular Dementia.<br><br>The 12/7/23 Quarterly Minimum Data Set (resident assessment tool) documented Resident #254 had severe cognitive impairment and required dependent assistance with transfers.<br><br>The Activities of Daily Living Care Plan updated 4/13/23 documented Resident #254 required total body lift with assist of two staff.<br><br>The January 2024 Certified Nurse Aide instructions were unavailable as Resident #254 was discharged from the facility/electronic medical record.<br><br>The 1/7/24 Resident Accident Report documented two (2) skin tears to the resident's right arm and a 1 cm by 1 cm abrasion to their head. The Certified Nurse Aide stated they transferred the resident using the sit to stand lift and the sling rubbed against the resident's arm. The resident was assessed and first aid was administered, the physician, wound team, and health care proxy were made aware. The 1/7/24 Registered Nurse #1 statement documented Certified Nurse Aide #2 reported they transferred Resident #254 using the Sit to Stand Lift and the sling rubbed against his arm. The 1/7/2024 Certified Nurse Aide #2 statement documented that when they assisted Resident #254 with transferring back to bed, the resident became agitated and scratched his right arm.<br><br>During an interview on 5/30/25 at 1:04 PM, the Assistant Director of Nursing stated that on 1/7/24 at 4:50 PM, Registered Nurse #1 observed skin tears to Resident #254's right upper arm, and an abrasion to their head, and interviewed Certified Nurse Aide #2 who stated the sling rubbed against the resident's arm.<br><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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/30/25 at 1:17 PM, the Director of Nursing stated the resident had required a 2-person assist with a total body lift with transfers. They stated they interviewed Certified Nurse Aide #2 the following morning (1/8/24), and Certified Nurse Aide #2 stated they transferred the resident without assistance.<br><br>During an interview on 5/30/25 at 4:05 PM, the Director of Nursing stated they could not access Certified Nurse Aide instructions because Resident #254 was discharged from the electronic medical record system. They stated documentation of the assistance Resident #254 required was documented on the Care Plan.<br><br>During an interview on 6/01/25 at 2:15 PM, Registered Nurse #1 stated on 1/7/24, Certified Nurse Aide #2 told them they transferred Resident #254 without asking for assistance. Registered Nurse #1 stated they had been administering medications in the same hallway and could easily have assisted Certified Nurse Aide #2 with the transfer if asked. Registered Nurse #1 further stated Certified Nurse Aide #2 had asked them for assistance on prior days and they expected Certified Nurse Aide #2 would ask for assistance if needed. They stated the resident's transfer status had not changed recently. Registered Nurse #1 stated if the Resident's transfer status had changed recently, they would have reported the change to the Certified Nurse Aides when they came in. They stated the change of shift report given by the nurse to the Certified Nurse Aides included whatever changes had occurred on the previous shifts. Registered Nurse #1 stated Certified Nurse Aides were responsible for checking the computer for resident transfer status or ask the nurse if they were unsure. They stated when they asked, Certified Nurse Aide #2 denied checking the CNA instructions prior to transferring the resident.<br><br>During an interview on 6/02/25 at 8:51 AM, the Director of Nursing stated for transfers, Resident #254 required 2-person assistance with total body lift starting on 4/13/2023. The Director of Nursing stated the care plan was documented on the Certified Nurse Aide Touch, (Certified Nurse Aide instructions). During a review of the ADL (Activities of Daily Living) Data Report, the Director of Nursing stated Certified Nurse Aide #2 provided care to Resident #254 thirteen (13) days prior to the 1/7/24 incident, on 12/23/23 and 12/24/23, and had documented providing 2-person assistance with transfers on those dates. The Director of Nursing stated on 1/8/24, Certified Nurse Aide #2 stated they transferred Resident #254 by themselves.<br><br>During an interview on 6/02/25 at 10:49 AM, Certified Nurse Aide #2 stated on 1/7/2024, they transferred Resident #254 without assistance. They stated they were aware Resident #254 required 2-person assistance. They stated they were made aware of how to transfer residents from either the Certified Nurse Aide Touch (Certified Nurse Aide instructions) or from the nurse. They stated they received verbal report if there were changes in the resident's status.<br><br>10 NYCRR 415.12(h)(2) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on record review and interview conducted during the Recertification and Abbreviated surveys (NY 00350287) from 05/28/25 to 06/04/25, the facility did not ensure there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, on 3 of 21 days from 7/15/24 through 8/4/24 and 2 of 31 days from 5/1/25 through 5/31/25 the facility did not meet minimum staffing requirements for Certified Nurse Aides as documented in the Facility Assessment.<br><br>The findings included:<br><br>The Facility Assessment, revised 1/2025, documented the following minimum requirements. Day shift: five Registered Nurses, one Licensed Practical Nurse, and twenty-two Certified Nurse Aides. Evening shift: three Registered Nurses, three Licensed Practical Nurses, and seventeen Certified Nurse Aides. Night shift: four Registered Nurses: two Licensed Practical Nurses and twelve Certified Nurse Aide.<br><br>Daily staff sheets from 7/15/2024 through 8/5/2024 documented during the day shift on 7/20/24 there were 18/22 Certified Nurse Aides, 7/21/2024 there were 14/22 Certified Nurse Aides, and 7/28/2024 there were 19/22 Certified Nurse Aides.<br><br>Daily staff sheets from 5/1/2025 through 5/31/2025 documented during the day shift on 5/24/25 and 5/25/25 there were 19/22 Certified Nurse Aides.<br><br>During the Resident Council Meeting on 5/20/25 at 1:49 PM, Resident #1 stated they felt degraded when they need to utilize an adult brief for bowel movements because the unit was short-staffed and staff were not available to assist them to the bathroom. Resident #101 stated they required assistance with oxygen approximately two months ago during the night shift and staff were not available to assist due to assisting other resident and not enough staff. They stated they rang the call bell which was not answered for an extended length of time.<br><br>During an interview on 5/30/25 at 1:42 PM, Certified Nurse Aide #9 stated their unit usually had between three and five Certified Nurse Aides, with three occurring frequently. They stated when three Certified Nurse Aides were assigned to the unit, cares were rushed and stressful. They stated residents frequently complained of long wait times for cares. They stated they were frequently asked to accept overtime due to callouts and were also assigned to other units to assist with coverage.<br><br>During an interview on 05/30/25 at 1:58 PM, Licensed Practical Nurse #5 stated the facility has reduced Nursing staffing in the last year. They stated optimal staffing for Certified Nurse Aides on the unit was four to five Certified Nurse Aides during day and evening shifts, however, the unit frequently only had three due to last minute callouts. They stated reduced number of Certified Nurse Aides causes delays in cares. They stated residents and family representatives frequently complain of short staffing and delays in care.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview and observation on 5/30/25 at 1:47 PM and 6/2/25 at 1:57 PM, the Staffing Coordinator stated they were aware the facility did not meet minimum staffing requirements on some dates between 7/15/24 through 8/4/24 and 5/1/25 through 5/31/25 and 7/15/24. They stated they were aware of facility minimum staffing guidelines which were updated (lowered) 7/15/24. They stated the goal was to meet or exceed daily minimum staffing numbers. When the minimum staffing numbers were not met, staff were distributed throughout units by Nursing Supervisors. They stated the main reason for not meeting minimum staffing requirements was due to staff call-outs. They stated they were not allowed to overstaff to cover callouts.<br><br>During an interview on 06/02/25 at 02:36 PM, the Director of Nursing stated Certified Nurse Aides were redistributed to units based on census when minimum staffing numbers were not met. They stated staff turnover was relatively low, but some Certified Nurse Aides leave their position due to making more money working for staffing agencies.<br><br>10 NYCRR 415.13(a)(1)(i-iii)] |