STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335832	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New York State Veterans Home at Montrose	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure a resident's right to be free from physical abuse. This was evident for one (1) (Resident #1) of four (4) residents reviewed for abuse. Specifically, on 03/01/2026 Certified Nurse Aide #1 is observed on video surveillance that was provided by Resident #1's representative, in Resident's #1 room striking the resident on the top of their head with a broom, grabbing Resident #1 by the neck and placing them in a reclining back wheelchair, and using their left hand to strike Resident #1 on the left side of their neck. Facility staff confirmed they observed recorded video footage on 03/02/2026 of Certified Nurse Aide #1 striking Resident #1 on the left side of their neck on 03/01/2026. This resulted in psychosocial harm to Resident #1 that is not immediate jeopardy.The findings are:The facility policy titled Abuse Prohibition, last reviewed 08/2016 documented the facility shall train all staff at orientation and ongoing about appropriate interventions to deal with aggressive residents and how to recognize signs of burnout, frustration, and stress that may lead to abuse.Resident #1 had diagnoses of Alzheimer's dementia and diffuse traumatic brain injury (damage throughout the brain from a sudden impact) with less than 30 minutes of loss of consciousness. The Minimum Data Set (an assessment tool) dated 12/15/2025, documented Resident #1 was severely cognitively impaired, independent in ambulation, required supervision with transfers, and was dependent on staff for toileting, showering, and personal hygiene.The Comprehensive Care Plan related to abuse was created 12/29/2025 and documented Resident #1 was at risk for being the victim of abuse related to their aggressive behavior and would be monitored to ensure their safety. The Nursing Note dated 02/28/2026 documented Resident #1 was readmitted from the hospital at 4:45 AM and was placed on one-to-one supervision. Resident #1 became agitated later in the day and wandered the unit cursing loudly.The Nursing Note dated 03/01/2026 documented Resident #1 was calm and cooperative during care in the morning and became agitated at 12:40 PM, cursing at the nurse, wandering the unit, and refusing medication.The Nursing Note dated 03/02/2026 at 6:57 AM documented Resident #1 was observed sleeping in bed and was cooperative with care when they woke up at 5:00 AM.The Nurse Practitioner Note dated 03/02/2026 at 10:20 AM documented Resident #1 became agitated and attempted to strike staff and another resident. Resident #1 was transferred to the hospital for a psychiatric evaluation.The Nurse Practitioner Note dated 03/03/2026 at 12:09 AM documented Resident #1 returned to the facility from the hospital at approximately 10:30 PM. On 03/02/2026, the resident's Representative showed facility staff camera surveillance footage of an incident involving Resident #1 and facility staff that occurred in Resident #1's room on 03/01/2026 at approximately 4:15 PM. The Administrator was immediately made aware.The Facility Reported Incident created 03/02/2026 at 11:26 PM documented Resident #1's Representative showed Registered Nurse #4 a hidden camera surveillance footage on their phone of Certified Nurse Aide #1 striking Resident #1 with their left hand on the left side of their neck on 03/01/2026 at approximately 4:15 PM.The facility Resident Accident Report dated 03/03/2026 documented Licensed Practical Nurse #3 and Registered Nurse #4 provided written statements confirming hidden camera surveillance footage from Resident #1's room which showed Certified Nurse Aide #1 using their hand to strike the left side of Resident (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	#1's neck. Certified Nurse Aide #1 provided a written statement that they raised their hand to defend against Resident #1 who was swinging their arms and fists. Certified Nurse Aide #1 was immediately removed from the schedule. The facility determined staff to resident contact did occur and facility is pursuing termination from employment for Certified Nurse Aide #1.During an interview on 03/05/2026 at 10:14 AM, the Assistant Administrator stated the facility's surveillance footage of the hallway outside of Resident #1's room showed Head [NAME] #5 obtaining a broom and dustpan from a hallway closet and handing it to Certified Nurse Aide #1, who is off camera inside the doorway to Resident #1's room. Per Head [NAME] #5, they were not aware of an incident occurring nor did they hear anything from the hallway outside Resident #1's room. Resident #1's Representative had their own hidden camera surveillance footage of the incident between Resident #1 and Certified Nurse Aide #1; however, the facility has not obtained a copy for purposes of their own investigation. Certified Nurse Aide #1 was hired in May 2025 and received orientation that included abuse prevention training. Certified Nurse Aide #1 had no prior allegations of abuse from any other residents in the facility. Certified Nurse Aide #1 was not scheduled to work on 03/02/2026 and they were removed from the facility schedule and placed on administrative leave on 03/03/2026 pending completion of investigation. The facility filed a report with local law enforcement on 03/03/2026 and reported the incident to the New State Department of Health on 03/02/2026. During an interview on 03/05/2026 at 11:24 AM with Resident #1's Representative, they stated they placed the hidden camera in Resident #1's room to determine triggers for the resident's behavior and frequent hospitalizations. The camera surveillance footage from 03/01/2026 at 4:15 PM revealed Resident #1 was struck by Certified Nurse Aide #1 on the left side of their neck. Resident #1's Representative stated this interaction with staff would have caused Resident #1 to be fearful and increasingly agitated and aggressive if they were cognitively intact.During an interview on 03/05/2026 at 1:12 PM, Head [NAME] #5 stated they were assigned as the second staff member responsible for constantly supervising and monitoring Resident #1 on 03/01/2026. Head [NAME] #5 stated they were not clinical staff and did not enter Resident #1's room when Certified Nurse Aide #1 brought the resident in there to provide care. Head [NAME] #5 stated they were stationed in the hallway outside Resident #1's room on 03/01/2026 at around 4:15 PM and Certified Nurse Aide #1 opened the door and asked for a broom from the hallway closet. Head [NAME] #5 stated they did not hear any commotion, altercation, yelling, or noise from Resident #1's room after they brought the broom to Certified Nurse Aide #1.An interview was conducted on 03/05/2026 at 2:08 PM with Licensed Practical Nurse #3 and they stated they observed camera surveillance footage on the personal cell phone of Resident #1's Representative on 03/02/2026 and saw Certified Nurse Aide #1 strike Resident #1 on the left side of their neck.Registered Nurse #4 was interviewed on 03/06/2026 at 11:10 AM and stated they and Licensed Practical Nurse #3 viewed the camera surveillance footage presented by Resident #1's representative and saw Certified Nurse Aide #1 striking Resident #1. They immediately reported the incident to the Administrator. Resident #1 was assessed with no physical injury noted.Medical Doctor #1 was interviewed on 03/06/2026 at 10:43 AM and stated Resident #1 is severely cognitively impaired and did not appear to recall the incident when they assessed the resident on 03/03/2026; however, if Resident #1 were cognitively intact, the facility would expect to monitor for adverse effects and reactions like agitation and fearfulness that could potentially arise after the resident was a victim of staff abuse.An interview was conducted on 03/06/2026 at 12:32 PM with the Acting Director of Nursing and they stated their investigation determined that physical contact did occur between Certified Nurse Aide #1 and Resident #1 as reported by Licensed Practical Nurse #3 and Registered Nurse #4 after viewing camera surveillance footage shown by Resident #1's Representative. As a result, the facility determined that abuse did occur, and that Certified Nurse Aide #1 would be terminated from employment.At a meeting with Resident#1's Representative on 03/11/2026 at 6:06 PM, Resident #1's Representative used their personal cell phone to show hidden camera surveillance footage of Resident #1's room with a date and timestamp from 03/01/2026 between 4:11 PM to 4:20 PM. The footage revealed at 4:17 PM (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Certified Nurse Aide #1 raised a small black broom in their right-hand above Resident #1 and struck Resident #1 on the top of their head once with the end of the broom. Resident #1 responded by saying Ouch and continued to pace in their room. At 4:19 PM, Certified Nurse Aide #1 grabbed Resident #1 by the neck and roughly placed the resident into a reclining back wheelchair. Certified Nurse Aide #1 moved to the front of Resident #1's wheelchair. Resident #1 used their arms to shove Certified Nurse Aide #1 away from them. Certified Nurse Aide #1 used their left hand to strike Resident #1 on the left side of their neck. Both Resident #1 and Certified Nurse Aide #1 move out of camera view and Resident #1 was heard yelling Ow three times and cursing. Certified Nurse Aide #1 then positioned Resident #1 in camera view again with the wheelchair tilted back preventing Resident #1 from getting up without staff assistance. 10 NYCRR 415.4(b)(1)(i)