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	03/24/2026

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the abbreviated survey from 03/11/2026 to 03/24/2026, the facility did not ensure the resident's right to self-determination. This was evident for one (1) (Fair Haven Unit) of six(6) resident units reviewed for resident rights. Specifically, on 03/07/2026 and 03/08/2026 the Fair Haven Unit (which is also the memory care unit with residents with impaired cognitive abilities) Day room, needed to undergo repairs. The day room had a sensory room and two bathrooms. The twenty (20) residents on the Fair Haven Unit including Resident #3, #4, and #5, were placed in the dining room causing an interruption of their daily routine and how the residents spent their leisure time before and after lunch and dinner on 03/07/2026 and 03/08/2026. There was no documented evidence that resident representatives were notified prior or were involved in choosing how the residents spent their leisure time during the repairs. The findings are:The facility policy titled Resident [NAME] of Rights dated 09/2022 documented the resident had the right to participate in planning of care and services.Resident #4 had diagnoses of Alzheimer's dementia and chronic kidney disease. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #4 was severely cognitively impaired and had their family participate in the assessment.Resident #5 had diagnoses of dementia and anxiety disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #5 was severely cognitively impaired and had their family participate in the assessment.Resident #3 had diagnoses of Alzheimer's dementia and hypertension.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #3 was severely cognitively impaired and had their significant other participate in the assessment.The facility Grievance and Resolution Form dated 03/09/2026 documented a grievance investigation was in progress related to reports of Fair Haven Unit residents being kept in their dining room over the weekend.The facility Census List dated 03/11/2026 documented there were 20 residents on the Fair Haven Unit including Resident #3, #4, and #5. During an interview on 03/11/2026 at 6:37 PM, Resident #3's Representative stated the 20 Fair Haven Unit residents were displaced from their unit dayroom and common area due to a heating repair issue on 03/07/2026 and 03/08/2026. Some residents were upset and distraught at the disruption to their daily routine as the alternatives provided did not include an area to descalate such as the sensory room as all the residents have significant cognitive impairments. The families were not notified or involved in the facility decision/plan to move the residents into the dining room for the entire weekend. During an interview on 03/23/2026 at 3:01 PM, the Deputy Administrator stated the 20 Fair Haven Unit residents did have a change in their daily routine on 03/07/2026 and 03/08/2026. The Deputy Administrator stated they became aware of a malfunctioning heater in the Fair Haven dayroom on 03/06/2026 and directed staff to place residents in the Fair Haven dining room for leisure time throughout the day. Staff were directed to also bring activities and a television for residents to use while in the dining room. The Deputy Administrator stated they did not inform families and representatives of the Fair Have Unit residents prior to the disruption in daily routine and residents and their representatives were unable to choose how the residents spent their leisure time in before and after lunch and dinner on 03/07/2026 and 03/08/2026. 10 NYCRR 415.5(d)(1)(2)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews, and record review conducted during the abbreviated survey from 03/11/2026 to 03/23/2026, the facility did not ensure the resident's right to resolve grievances. This was evident for two (Resident #1 and #6) of four residents reviewed for resident rights. Specifically, 1) Resident #1's Representative was not provided with an opportunity to file a written grievance in relation to concerns with the resident's medication regime and care received, and 2) Resident #6's Representative was not provided the opportunity to file a written grievance in relation to concerns with medication regime and care received. The findings are:The facility policy titled Resident [NAME] of Rights dated 09/2022 documented residents had the right to voice grievances about care or services and could expect the facility to promptly investigate and try to resolve their concerns.1) Resident #1 had diagnoses of Alzheimer's dementia and diabetes mellitus.The Minimum Data Set 3.0 (an assessment) dated 12/08/2025 documented Resident #1 was severely cognitively impaired, their family participated in the assessment, and their family provided information related to Resident #1's discharge status.The Medical Doctor dated 12/29/2025 documented Resident #1 was evaluated by Psychiatry with recommendations to continue Klonopin use while Resident #1's Representative requested that Klonopin use be discontinued.The Social Work Note dated 12/29/2025 documented Resident #1's Representative attended the resident's initial care plan meeting and expressed concerns related to medication administration. Nursing staff and the Medical Doctor would address the Representative's concerns.The Social Work Note dated 01/23/2026 documented Resident #1's Representative attended a care plan meeting with the interdisciplinary team in attendance. Medical Doctor and Psychiatry recommendations were explained to Resident #1's Representative and the Administrator informed the Representative that Resident #1 would receive the recommended care of the clinicians at the facility while a resident of the facility.There was no documented evidence Resident #1's Representative was offered the opportunity to file a grievance in writing for care and medication concerns expressed to facility staff.During an interview on 03/11/2026 at 6:06 PM, Resident #1's Representative stated they communicated concerns to the facility staff related to the resident's medication regime, missing dentures, and ensuring Resident #1 was kept in areas under video surveillance for safety. Resident #1's Representative stated they emailed with Social Worker #1 and the facility's administration but were not offered the opportunity to file a grievance for any of these concerns and, although they met with facility staff on multiple occasions, felt as though these concerns were unresolved.2) Resident #6 had diagnoses of Parkinson's disorder and depression. The Minimum Data Set 3.0 dated 12/18/2025 documented Resident #6 had short term memory deficits and was independent in decision making. Resident #6 had falls within the last two to six months. Resident #6 required partial/moderate assistance with toileting and was required supervision or was independent with all other activities of daily living.The Nursing Note dated 12/21/2025 documented Resident #6 requested not to have a specific Certified Nurse Aide assigned to them due to their skin color. The Social Work Note dated 12/23/2025 documented Resident #6 had an incident where the resident demanded their latanoprost eye drops be administered at their request which differed from the Medical Doctor Order.There was no documented evidence Resident #6, or their Representative, was offered the opportunity to file a grievance for any of their unresolved concerns with care and medication.During a telephone interview on 03/20/2026 at 1:05 PM, Resident #6's Representative stated they expressed concerns related to Resident #6's medication regime and the resident's number of falls in the facility and did not feel as though their concerns have been addressed or resolved.During an interview on 03/23/2026 at 10:55 AM, Social Worker #1 stated they were assigned to Resident #1 and Resident #6. The interdisciplinary team met with both Representatives of Resident #1 and Resident #6, sometimes with facility Administration present, and they were aware that both Representatives had concerns regarding medication administration. Social Worker #1 stated they (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	believed the Representatives' concerns were being addressed through the care plan meetings and did not think to file a written grievance for Resident #1 or Resident #6 related to any of their care concerns.During an interview on 03/23/2026 at 3:30 PM, the Administrator stated the grievance process allowed residents and families to have their concerns investigated and receive a resolution in writing. The Administrator stated they were present at care plan meetings held with Resident #1's Representative and believed all the Representatives concerns were being addressed; therefore, filing a grievance did not seem necessary. The Administrator stated they intended to foster better communication and collaboration with Resident #6 and their family and stated filing a written grievance to address their concerns would have been appropriate. The Administrator stated that there were no grievance investigations on file for both Resident #1 and Resident #6.10 NYCRR 415.3(d)(1)(ii)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during survey (2695131), the facility failed to ensure that a resident received supervision and devices necessary to prevent accidents for one (1) (Resident #6) of three (3) residents reviewed for accidents. Specifically, Resident #6 had eight (8) falls between 10/06/2025 and 03/17/2026. On 03/17/2026 Resident #6 fell and sustained a laceration to the back of their head requiring six (6) stitches. This resulted in actual harm to Resident #6 that was not Immediate Jeopardy.The findings are:The undated facility policy titled Accident and Incident Reporting documented fall risk assessments were completed by registered nurses quarterly, annually, upon significant change, and after a fall. All falls will be reviewed at the designated accident and incident review meeting with the interdisciplinary team and any additional team members deemed necessary. Resident #6 had diagnoses of Parkinson's (a degenerative neurological disorder) and depression. The Minimum Data Set 3.0 (a resident assessment tool) dated 09/17/2025 documented Resident #6 had mild cognitive impairments, required partial to moderate assistance with toileting, personal hygiene, and bathing, was independent in transfers in and out of bed, and had no falls since their last assessment. The Comprehensive Care Plan related to falls initiated 03/24/2025 documented Resident #6 had a history of falls, had impaired mobility related to their Parkinson's diagnosis, and was noncompliant with safety teachings. Interventions to prevent falls included gradually changing the resident's position to prevent postural hypotension, gradual dose reduction as per doctor's order, monitor for side effects of psychotropic medication, and psychiatric consultation as needed. The care plan was updated on 09/05/2025 to reflect Resident #6 had been given a fall risk identifier. Physician Orders as of 03/16/2026 documented Resident #6 was ordered to receive Ativan 0.5mg every eight (8) hours as needed and at 9:00PM as needed for anxiety. Resident #6 was also ordered to receive trazodone 50mg at 9:00PM for insomnia. The Nursing Note dated 10/06/2025 documented Resident#6 fell in their room while trying to stand and turn. No injury was noted. The Accident/Incident Report dated 10/06/2025 documented Resident #6 fell in their room and the statement provided by Certified Nurse Aide #8 documented Resident #6 had reported their genital area hurt, causing the resident to get out of bed. A 10/07/2025 Care Plan intervention included Physical Therapy evaluation (a refresh of a 03/24/2025 intervention) and Resident #6 educated to use call bell for assistance. The Medical Doctor Note dated 10/08/2025 documented Resident #6's pelvis x-rays were negative for fracture. Nursing Notes and Accident/Incident Reports dated 10/18/2025 documented Resident #6 fell and hit their head while trying to ambulate to the bathroom. The Fall Risk assessment dated [DATE] documented Resident #6 was at high risk for falls. Care Plan note dated 10/18/2025 documented Resident #6 sustained a six (6) centimeter round hematoma to left forehead with a two (2) centimeter open area with scant blood. Resident transferred to the hospital for evaluation. There is no documented evidence of updated interventions to the resident's care plan. Nursing Notes and Accident/Incident Report dated 10/31/2025 documented Resident #6 fell from a chair in their room. Care Plan note dated 10/31/2025 documented Resident #6 sustained an abrasion to the left knee and small skin tear to the left upper thigh with no bleeding. Intervention for neuro checks for 48 hours and every 15-minute checks for 72 hours. There is no documented evidence of long-term interventions to assist in helping to prevent additional falls. The Minimum Data Set 3.0 dated 12/18/2025 documented Resident #6 had short term memory deficits and was independent in decision making. Resident #6 had falls within the last two (2) to six (6) months. Resident #6 required partial/moderate assistance with toileting, showering, and personal hygiene. Resident #6 required assistance with eating and dressing. Resident #1 was independent in ambulating up to 100 feet and chair-to-bed transfers. Nursing Notes dated 12/22/2025 documented Resident #6 fell in the unit hallway while walking back to their room. No injury was noted. The Accident/Incident Report dated 12/22/2025 documented Resident #6 fell (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	while ambulating back to their room. The Falls Risk assessment dated [DATE] documented Resident #6 was at high risk for falls. The Comprehensive Care Plan related to falls was revised on 12/23/2025 to include interventions for staff to assure hygiene cares were provided promptly to Resident #6, comfortable positioning, possessions were within reach, and the resident's bed was at proper height to promote out of bed transfers. Resident #6 was provided with non-skid socks while in bed, was encouraged to use their call bell to call for staff assistance, and they would receive hourly visual checks by staff. The Nursing Note and Accident/Incident Report dated 01/02/2026 documented Resident #6 was observed sitting on the floor by the housekeeper. No injury was noted. There was no documented evidence that a Fall Risk Assessment was completed, or that the care plan related to Resident #6's falls was revised to address the resident's fall on 01/02/2026. The Nursing Note and Accident/Incident Report dated 01/05/2026 documented Resident #6 self-reported to nursing staff that they fell in their room and were able to pick themselves up from the floor.A Fall Risk assessment dated [DATE] documented Resident #6 was at high risk for falls. Care Plan Note dated 01/05/2026 documented resident fell with no injury. Intervention for neuro checks and every 15-minute checks for 48 hours. On 01/06/2026 hip protectors (padded briefs designed to prevent hip fractures) were provided. On 01/07/2026 Resident #6 to be reminded to use call bell for staff assistance (a refresh of a 12/23/2025 intervention). The Nursing Note and Accident/Incident Report dated 02/07/2026 documented Resident #6 fell out of bed while reaching for a personal item in their bedside dresser drawer. No injury was noted. The Falls Risk assessment dated [DATE] documented Resident #6 was at high risk for falls. Regarding Resident #6's fall on 02/07/2026 there was no documented evidence that the care plan related to falls was revised with interventions to address falls. There was an intervention for neuro checks for 48 hours and every 15-minute checks for 72 hours. On 03/11/2026 at 4:15PM, Resident #6 had their room door closed and refused to have visitors in the room or to be interviewed. The Nursing Note dated 03/15/2026 documented nursing staff were made aware that Resident #6 fell while out on pass with family, but the family reported the resident did not hit the floor and did not sustain any injury. Nursing Notes dated 03/17/2026 documented the nurse answered Resident #6's call bell and found the resident kneeling on their bedroom floor with Certified Nurse Aides #10 and #11 standing next to them. Certified Nurse Aide #10 reported Resident #6 fell and hit their head. Resident #6 was observed with a 6.6-centimeter laceration (cut) and bleeding to the back of their head. The family and doctor were made aware, and Resident #6 was transferred to the hospital for evaluation. The Accident/Incident Report dated 03/17/2026 documented Resident #6 reported they fell backwards in their room and hit their head on a bedside table drawer. A witness statement from Certified Nurse Aide #10 documented Resident #6 was walking around their room and telling the aide not to touch them while Certified Nurse Aide #10 told the resident to sit down. The witness statement documented Resident #6 refused to sit down and fell, hitting their head on their nightstand. A witness statement from Certified Nurse Aide #11 documented they were in Resident #6's room asking the resident to sit down and put their pants on when Resident #6 spun around to tell the aides not to touch them and fell, hitting their head on a nightstand. Regarding Resident #6's fall on 03/17/2026 there was no documented evidence that the care plan related to falls was revised with interventions to address falls. The Nursing Note dated 03/18/2026 documented Resident #6 returned from the hospital with six (6) stitches towards the right side of the back of their head. The Medical Doctor Note dated 03/18/2026 documented Resident #6 was walking with their walker and reaching for their wheelchair when they fell backward hitting their head on 03/17/2026. Resident #6 had gait (pattern of walking) disorder and an acute laceration to the scalp. During a telephone interview on 03/20/2026 at 12:27 PM, Complainant #1 stated the facility has not had any meaningful care plan meetings with both the family and Resident #6 in attendance to discuss the resident's fall risk and prevention plan. Resident #6 fell again on 03/17/2026 and sustained a painful injury to the back of their head requiring stitches. Complainant #1 stated they asked facility staff about using floor mats or other environmental alterations for safety but were not aware of any changes made to the resident's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	room or furniture. During an interview on 03/20/2026 at 3:35 PM and 03/23/2026 at 1:02 PM, Medical Doctor #1 stated Resident #6 was at high risk for falls and fell frequently. Medical Doctor #1 stated they evaluated Resident #6's medication regime to determine any contributing factors to fall risk. Resident #6 received several of Parkinson's medications that the resident inconsistently was compliant with taking. Resident #6 did receive Ativan to treat their anxiety, but it was prescribed on as needed basis and Resident #6 has only had one (1) administration of this medication in the last 30 days. Medical Doctor #1 stated staff on the unit were aware Resident #6 was at high risk for falls and frequently monitored the residents. Medical Doctor #1 was unable to specify how frequently staff monitored and rounded on Resident #6. Medical Doctor #1 stated Resident #6 fell on [DATE] resulting in a laceration to the back of their head requiring six (6) stitches. Resident #6 was transferred to the hospital and returned on 03/18/2026. Stitches should be removed in a week. Medical Doctor #1 stated this fall resulted in a painful and harmful injury for Resident #6; however, the resident should be able to recover from it within a few weeks. Certified Nurse Aide #8 was interviewed on 03/23/2026 at 12:15 PM and stated they were aware that Resident #6 fell while out on pass with their family and then fell in their room on 03/17/2026. Certified Nurse Aide #8 stated they were working and present on the unit that day and heard that two (2) other certified nurse aides were in the room with Resident #6 when the resident attempted to turn around and then fell. Certified Nurse Aide #8 stated they were instructed to ensure Resident #6 had their bed in the lowest position and to ensure proper technique and positioning when assisting the resident with transferring out of bed. Certified Nurse Aide #8 stated they frequently checked on Resident #6 because the resident frequently used the call bell and needed assistance. Certified Nurse Aide #8 stated they were also instructed to answer Resident #6's call bell promptly to prevent the resident from trying to get up unassisted. During an interview on 03/23/2026 at 12:31 PM, Registered Nurse #9 stated Resident #6 was at high risk for falls and fell last week resulting in stitches to the back of their head. Resident #6 has been weaker since that incident and now requires staff assistance to get out of bed. Resident #6 previously was able to walk in the hallway with their walker but didn't look like they were able to ambulate without staff assistance now. Registered Nurse #9 stated they made sure to round frequently on all the residents on their side of the unit. They were not aware of any special fall prevention or rounding instructions for Resident #6. During an interview on 03/23/2026 at 1:32 PM, the Acting Director of Nursing stated residents were assessed by a Registered Nurse following a fall and interventions to prevent another fall were immediately put in place. Resident falls were discussed in the next morning meeting with the interdisciplinary team and the team determined whether any further interventions should be added to the resident's falls prevention care plan. All residents were placed on 15-minute visual checks for 48 hours following a fall incident. The Acting Director of Nursing stated Resident #6 had several falls and current interventions to prevent future falls included proper positioning of the resident's bed, keeping items within reach, and answering the call bell promptly. Resident #6 was also on hourly visual rounds but all residents regardless of fall risk were on hourly visual rounds. There have not been any recent interdisciplinary team meetings with the family and Resident #6 to discuss the resident's fall risk and prevention plan. The Acting Director of Nursing stated they were unsure what devices the physical therapy recommended for Resident #6 and were unsure whether the resident was provided with a reacher (a mobility aid to pick up objects out of reach). The Acting Director of Nursing stated they were unaware of whether Resident #6 was appropriate for floor mattresses and stated they would need to follow up on whether an environmental assessment was done to determine safety of Resident #6's room and furnishings. During an interview on 03/23/2026 at 3:32 PM, the Administrator stated they plan to foster better communication and collaboration with Resident #6 and their family to ensure the resident's plan of care included effective and individualized interventions to keep the residents safe. The interdisciplinary team would ensure an environmental assessment was done to maximize resident safety. The Administrator stated Resident #6 did sustain a painful and injurious fall on 03/17/2026 and the team were looking for ways to address Resident #6's unique challenges from (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	their Parkinson's diagnosis and other comorbidities. 10 New York Codes, Rules, and Regulations 415.12(h)(1)