STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335208	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Manor Nursing Home	40 Park Street Norwich, NY 13815

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure resident's right to personal privacy and confidentiality of their personal and medical information for one (1) of one (1) resident (Resident #2) reviewed. Specifically, Resident #2 had a binder located in a holder outside their room, accessible to all, containing staff entries about the resident's personal care. Findings include: The undated facility policy Resident Rights, documented residents had the right to privacy and confidentiality of records. The facility policy Quality of Life – Dignity, revised 08/2025, documented staff should maintain an environment in which confidential clinical information was protected, for example: signs indicating the resident clinical status or care needs should not be openly posted in the resident's room unless specifically requested by the resident or family member. Resident #2 had diagnoses including depression. The 12/27/2025 Minimum Data Set assessment documented the resident had intact cognition; rejected care one (1)- three (3) of seven (7) days; and did not have behavioral symptoms. The Comprehension Care Plan initiated 09/26/2025 and revised 03/06/2026 documented the resident had the potential of accusatory behavior related to attention seeking behaviors. Interventions included staff would document on the log prior to entering and exiting resident room. There was no documented evidence of the location of the log. During an observation on 04/03/2026 at 10:29 AM, there was a white binder with a communication log in a holder on the wall outside Resident #2's room. The binder was located up high and had a STOP sign in red on the outside of the binder. The binder included dates, times, and staff initials of when they entered resident's room. The binder was accessible to anyone who passed by the resident's room. The communication log binder documented multiple daily entries including: -on 03/20/2026 at 3:55 PM, the resident had incontinence care completed. -on 04/03/2026 at 10:30 AM, the resident refused their morning care and needed coffee. -on 04/05/2026 at 11:30 PM, the resident requested as needed pain medication. During an interview on 04/01/2026 at 10:03 AM, Ombudsman #12 stated Resident #2 had a book outside their room that staff used to sign in and out of the resident's room. The binder was in the hallway and accessible to anyone. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/2026 at 1:26 PM, Resident #2 stated they had a problem with the book outside their door. They did not know what was in the binder. Staff were supposed to write down what they were doing. They stated they talked to the social worker about the book, the social worker said they would look into it, and nothing came of it. During an interview on 04/06/2026 at 11:30 AM, Certified Nurse Aide #13 stated there was a white binder for Resident #2 they signed when they went in and out of the resident's room. It was used to see how long they were in the resident's room. They stated they also documented things such as if they gave the resident a snack. During an interview on 04/06/2026 at 11:47 AM, Social Worker #14 stated Resident #2 did not have any grievances in the last three (3) months. During an interview on 04/06/2026 at 2:07 PM, Licensed Practical Nurse Unit Manager #3 stated the white binder was used anytime anyone entered and exited the resident's room. They documented anytime care was offered, medications were administered, activities done, and anyone that goes in the room for any purpose. They wrote their name, time, and what they were doing for the resident. The binder was high enough to not be accessible to other residents. They did not think about visitors being able to access the binder. The binder should probably be put behind the nurse's station. They stated Resident #2 had not complained about the binder to them. 10 New York Codes Rules and Regulations 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews (Intake #s 2714848 and 2729682) the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for one (1) of three (3) Residents (Resident #3) reviewed. Specifically, Resident #3 had facial hair and shaving was not offered. Findings include: The facility policy Activities of Daily Living, supported, revised 04/2025, documented appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, with the consent of the resident in accordance with their plan of care, including appropriate support and assistance with hygiene: (bathing, dressing, grooming and oral care).Resident #3 had diagnoses including quadriplegia (paralysis of all four limbs) and depression. The 11/21/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition and was dependent on staff for personal hygiene. The Comprehensive Care Plan revised 02/06/2026 documented the resident required assistance with activities of daily living and functional mobility. The was no documented evidence of the resident's preference for shaving or presence of facial hair. The 03/2026 resident care instructions documented the resident required moderate assistance of one (1) for bathing and stand by assistance for personal hygiene.The following observations of Resident #3 were made:-On 04/01/2026 at 11:29 AM with black facial hair, approximately 1 inch long on the left and right sides of their chin in a beard-like fashion and with a scant amount of black facial hair on their upper lip. Resident #3 stated staff did not offer to shave them, and they preferred to be shaved. -On 04/02/2026 at 10:45 AM in bed with black facial hair on the right and left sides of their chin and upper lip. The resident stated they hoped staff would offer to shave them today.During an interview on 04/03/2026 at 09:53 AM, Certified Nurse Aide #4 stated Resident #3 could verbalize if they would like to be shaved. If the resident asked, the certified nurse aides would shave them. If they observed facial hair, the certified nurse aides would shave the resident provided the resident agreed. They stated there were plenty of staff on the unit to meet the residents' needs.During an interview on 04/06/2026 at 02:07 PM, Licensed Practical Nurse Unit Manager #3 stated activities of daily living for dependent residents included brushing hair, assisting with bathing, and providing oral care and shaving. Resident #3 was cognitive and could make their needs known and should not have to ask to be shaved. The certified nurse aides should offer shaving to the resident. They stated it was undignified for Resident #3 to have facial hair if it was not their preference. 10NYCRR 415.12(a)(3)