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	05/03/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33421 Based on observation, record review, and interview during the recertification and abbreviated (NY00335434) surveys conducted 4/29/2024-5/3/2024, the facility did not review and revise the comprehensive care plan based on needs of the residents and responses to current interventions for 1 of 4 residents (Resident #47) reviewed. Specifically, Resident #47 had resident-to-resident altercations and their care plans were not reviewed and revised after the incidents to determine if current interventions were effective or if additional interventions were needed. Findings include: The facility policy Resident-to-Resident Altercations revised 12/2016 documented the facility was to make any necessary changes in the care plan approaches to any or all the involved residents. The facility policy Care Plans, Comprehensive Person-Centered revised 3/2023 documented the interdisciplinary team developed and implemented a person-centered care plan for each resident. Care plans were revised as information about the resident's condition changed. The interdisciplinary team would review and update the care plan when there was a significant change in the resident's condition. The facility policy Traumatic Brain Injury dated 5/2024 facility policy documented residents with a known or suspected history of a traumatic brain injury received a thorough assessment by the interdisciplinary team to determine their specific needs and capabilities. Regular interdisciplinary meetings were held to adjust care plans as needed. Resident #47 had diagnoses including traumatic brain injury, irritability, and impulse disorder. The 1/25/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, rarely made self understood or understood others, had inattention and disorganized thinking, had trouble concentrating daily, was short-tempered or easily annoyed most days, had physical and verbal behaviors directed towards others, required supervision or was independent for most activities of daily living, received an antipsychotic and antidepressant, and did not have active discharge planning to return to the community. The comprehensive care plan initiated 8/26/2-21 documented return to community discharge referral: the resident remained at the facility for long term care placement. The resident had not expressed wishes to leave the facility and the resident representative agreed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/7/2023 updated comprehensive care plan documented the resident had aggressor/behavioral symptoms of tensing up and clenching their fist, beating on their chest when agitated, and received psychotropic medications. Interventions included 15-minute checks, 1:1 monitoring for 3 days and assess as needed, attempt to find appropriate environment, attempt to increase activity for helping around the facility, attempt gradual dose reduction of medications, follow up with psychiatrist, initiate non-pharmacological interventions, provide 1:1 activities as needed, talking books or large print material, 1:1 activity visits for stimulation, engage in purposeful activities such as sweeping floors/wiping tables/wiping counters/washing dishes, keep resident in high visibility areas, and redirect. The 3/7/2024 at 8:30 PM incident report completed by registered nurse #18 documented Resident #47 was standing in the North Hallway in front of the unit dining room while Resident #49 was ambulating in the hallway heading in the direction of Resident #47. The residents had a verbal interaction and Resident #47 struck Resident #49 causing Resident #49 to fall to the floor and strike their head. Resident #47 went to their room immediately after being separated from Resident #49. Licensed practical nurse #14's witness statement documented they saw Resident #49 on the ground with Resident #47 standing over them. Licensed practical nurse #14 documented contributing factors to the incident were Resident #47 was known to have extremely violent outbursts and was not being properly supervised. Resident #47 was placed on 15-minute checks all shift for 3 days and the care plan was reviewed. There were no documented evidence Resident #47's care plan was reviewed to determine if interventions for aggressive behaviors remained effective following the 3/7/2024 incident. The 3/13/2024 at 6:44 PM progress note by licensed practical Nurse Manager #12 documented Resident #47's aggressive behavior was reviewed with the medical provider and the provider increased risperidone (antipsychotic) to 2 milligrams twice a day. The risperidone increase was not documented on the care plan. The 3/14/2024 at 11:12 AM social worker #13 progress note documented the facility's goal was to get Resident #47 transferred to a group-like setting. The care plan did not include potential discharge goals to a group setting. The 4/12/2024 at 10:18 PM licensed practical Nurse Manager #12's progress note documented Resident #47 had been seen by neurology in the past for traumatic brain injury and was last seen May 2023. The resident had aggressive intermittent disorder. Neurology notes documented the resident had behaviors for years with psychosis and paranoia. Neurology suggested the resident's behaviors be addressed by psychology. The 4/22/2024 at 4:20 PM incident report completed by licensed practical Nurse Manager #12 documented Residents #47 and #49 were at the nursing station. Resident #49 approached Resident #47 and Resident #49 began shaking their fist at Resident #47. Resident #47 shoved Resident #49 and then grabbed Resident #49's hands to prevent Resident #49 from hitting Resident #47. There were no observed verbal altercations prior to the incident. The residents were immediately separated and there were no injuries to either resident. The incident report documented both residents' care plans were updated, and the residents were placed on 15-minute checks for 3 days. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #47s care plan, updated on 4/23/2024, documented an intervention of 15-minute checks for 3 days. The intervention was in place prior to the 4/22/2024 incident. There were no documented evidence Resident #47's care plan was reviewed to determine if interventions for aggressive behaviors remained effective following the 4/22/2024 incident. Resident #47 was observed: - on 4/30/2024 from 10:27 AM until 10:45 AM, sitting in a straight back chair across from the North nursing station, looking up and down the hallway. The resident was not given any form of activity. The resident rose from the chair at 10:45 AM to go to a formal activity occurring on another unit. - on 5/1/2024 from 9:16 AM until 9:49 AM, standing in the unit dining room doorway with no activity or task. The resident walked and entered their room at 9:49 AM. At 10:09 AM, the resident was standing in the dining room doorway. Another resident began knocking on the activities department door located in the unit dining room. Resident #47 began yelling at the resident to stop the banging and became agitated. Staff immediately intervened and told the resident to stop yelling. Resident #47 returned to their room and closed the door. - on 5/1/2024 at 11:44 AM, seated at a table in the unit dining room, other residents were present in the room, and the TV was on. Another resident was continuously yelling out and other residents were telling them to stop yelling. Resident #47 began to get upset, swore, and raised their hands in the air. Staff intervened and asked Resident #47 to not swear. No tasks or independent activities related materials were offered to Resident #47. During an interview on 5/2/2024 at 3:20 PM, licensed practical nurse #14 stated resident specific care was documented in the care plan and care instructions, including behavioral interventions. Staff tried to intervene between Resident #47 and Resident #49 and separate them before the situations escalated. On 3/7/2024, the nurse was down the hall passing medications, the unit assistant made a verbal sound, the nurse turned, and saw Resident #49 going to the floor. The nurse got in front of Resident #47, told the resident to stop and go to their room, and the resident did. On 4/22/2024, the nurse stated they were passing medications, heard Resident #47 make a random noise, turned, and saw Resident #47 attempt to step in front of Resident #49. The residents got into a shoving match and staff were able to intervene prior to either getting injured. The nurse felt Resident #47 was not properly supervised both days of the incident. Interventions for Resident #47 were for staff to give the resident a simple task, a snack or drink, or an electronic tablet. Staff did not provide the resident those things prior to the incidents as it was difficult to know when the resident was going to have an impulsive behavior. During an interview on 5/2/2024 at 3:45 PM, unit assistant #15 stated Resident #47 had previous altercations with other residents, got a weird look on their face, and raised their fist prior to an altercation. On 3/7/24, the unit assistant was handing out bedtime snacks in the hallway, went into another resident's room, exited the room, and saw Resident #49 walking with a walker down the hall in front of the dining room. Resident #49 stated something to Resident #47, they did not hear what was said, Resident #47 drew their fist back and struck Resident #49 in the left cheek. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/3/2024 at 11:45 AM, the Director of Nursing stated a registered nurse initiated a specific care plan topic and any nurse was able to update the care plan once that was done. Each discipline was responsible for their own area in the care plan. The care plan, which incorporated the care instructions, included resident specific interventions. Resident #47's interventions were to watch for triggers and redirect with signs of agitation. Staff supervised both Residents #47 and #49 to prevent injury to another resident. Resident #47 lingered around the nursing station or unit dining room when out of their room and turned into an aggressor when they thought another individual was acting aggressively. There were no new interventions added after the 3/7/2024 incident and there should have been. The facility had busy boxes on the unit that were not added to the care plan interventions. Resident #47 used to have task-related interventions in the care plan that must have dropped off. The 15-minute checks were not new interventions and were only to be done for 3 days after each incident. A medical review was done for Resident #47 after the 3/7/2024 incident and that was not added to the care plan. The care plans were to be reviewed and updated with new interventions after each incident if altercations continued. The facility was also trying to find a more suitable setting for Resident #47 as they were a younger adult with a traumatic brain injury. The facility nursing staff had not had any traumatic brain injury training. During an interview on 5/3/2024 at 12:30 PM, the Administrator stated the expectation was for staff to follow the care plan and new interventions to be implemented with each resident-to-resident altercation. The Administrator expected staff to redirect Resident #47, have them remain around the nursing station for monitoring, and keep them occupied when out of their room. During an interview on 5/3/2024 at 1:11 PM, social worker #13 stated each resident's care plan was reviewed quarterly, annually, and with each significant change. Behavioral interventions were part of the care plan. The care plan was to be updated with each new behavioral intervention. Resident #47's care plan should have been reviewed and updated with each of the incidents and all planned interventions followed by staff. 10NYCRR 415.11(c)(2)(iii)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 37516 Based on observation, interview, and record review during the recertification survey conducted 4/29/2024 - 5/3/2024, the facility did not ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 1 of 2 residents (Resident #39) reviewed. Specifically, Resident #39 did not have their right resting hand splint applied as ordered. Findings include: The facility policy Adaptive Position Equipment dated 8/28/2007 documented the rehabilitation department staff would issue the prescribed equipment. The nursing supervisor would be responsible for ensuring the adaptive equipment would be consistently done on all shifts. It was the responsibility of nursing to investigate or locate the equipment if it became lost or misplaced. Resident #39 had diagnoses including diffuse traumatic brain injury with loss of consciousness and right upper extremity weakness. The 3/26/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required partial to moderate assistance with upper body dressing, supervision or touching assistance with personal hygiene, and had upper and lower extremity functional limitation on one side. The 4/9/2024 comprehensive care plan documented the resident had an alteration in activities of daily living performance related to a diagnosis of traumatic brain injury and the right arm had limitations in the fingers, wrist, and shoulder. Interventions, edited on 4/17/2024, were right hand resting splint, on 4 hours after AM care. A physician order dated 4/17/2024 documented right hand resting splint, on 4 hours after AM care once a day, 8:00 AM. The order was not listed on the medication administration record, the treatment administration record, or the certified nurse aide task documentation for staff to sign for the splint's use. The certified nurse aide care instructions as of 5/2/2024, with a start date of 7/19/2023, documented right hand resting splint, on 4 hours after AM care. The Point of Care Activities of Daily Living Category Report (certified nurse aide documentation) for April 2024 and May 2024 under the area of devices provided choices for cane/crutch, walker, wheelchair, limb prosthesis, and none of the above. It did not reflect a category for the application of splints or braces. There was no documented evidence in nursing progress notes from 4/29/2024-5//3/2024 the resident refused to wear their right hand resting splint. The resident was observed without a right hand resting splint applied: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/30/2024 at 9:22 AM sitting in their bed, dressed. Their right hand, with long fingernails, was contracted. When interviewed and asked if they wore a splint to their right hand, the resident pointed to their nightstand to the right side of their bed. The right hand resting splint was sitting on top of items on the nightstand, out of reach of the resident. - on 5/1/2024 at 10:04 AM the resident was not in their room. The right hand resting splint was sitting on the top of the nightstand. At 10:33 AM at an activity in the South dining room without their right hand resting splint. When interviewed about their right hand resting splint, the resident stated staff did not put it on. An unidentified resident sitting at the table with Resident #39 stated they never saw the splint on Resident #39, and it was supposed to be on for 4 hours each day. - on 5/3/2024 at 9:11 AM sitting in their wheelchair in their room. The right hand resting splint was lying on the bed. The resident stated, Look, not on. During an interview on 5/1/2024 at 10:48 AM certified nurse aide #8 stated the resident did have a splint for their right hand contracture that they thought the resident was supposed to wear during the day. The resident did not like to wear it and would slip it through their hand and hide it under the bed covers. During an interview on 5/1/2024 at 10:53 AM certified nurse aide #11 stated they got the resident out of bed that morning. The resident had a splint because their hand did not stretch out and the splint would prevent it from becoming worse. The resident was supposed to wear it during the day but sometimes the resident would tuck it in their pocket or hide it under the bed if they did not want to wear it. During an interview on 5/1/2024 at 11:05 AM the Director of Therapy stated the resident was supposed to be wearing their right hand splint for up to 4 hours a day due to their right hand contracture and it was to be applied by nursing staff. The resident had the right hand splint order for a long time. The resident was wearing it Monday (4/29/2024) because they went around and checked all the residents who were supposed to be wearing adaptive equipment devices. The resident was currently not being seen by therapy but had been seen on and off in the past, every 3-6 months. During an interview on 5/3/2024 at 11:43 AM licensed practical nurse Unit Manager #12 stated they expected certified nurse aides to follow the order programmed in the Kiosk (the electronic resident chart) so they would know the right hand resting splint was in Resident #39's plan of care. They expected the certified nurse aides to document any refusals by the resident to wear their right hand resting splint and to notify them of the refusals. If staff did report refusals, they would document it and place it on report. 10 NYCRR 415.12 (e) (2)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34459 37516 Based on record review and interview during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not ensure nursing staff had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with facility assessment for 2 of 2 licensed nurse records (registered nurse #6 and licensed practical nurse #7) reviewed. Specifically, registered nurse #6 and licensed practical nurse #7 did not receive annual competency evaluations to measure their pattern of knowledge, skills, abilities, and other characteristics to perform their work roles successfully as outlined in the 2023 facility assessment and per regulations. Findings include: The Facility Assessment Tool updated 10/2/2023 documented all staff members had or would have yearly competencies, or would receive the facility orientation, including competencies, if employed for less than one year. The facility did not have a policy and procedure for competency evaluations. Nursing personnel records were reviewed for registered nurse #6 and licensed practical nurse #7. Both staff had been employed for over a year and there were no competency evaluations within the last year. During an interview on 5/2/2024 at 10:15 AM the Corporate Director of Nursing stated nursing personnel files were kept in the Human Resources office. They currently did not have a staff educator as the position had been vacant since Fall of 2023. They were planning to transition a Unit Manager into the role of licensed practical nurse/Assistant Director of Nursing to help with staff education. The current Director of Nursing had been performing the staff educator role since January 2024. During a follow-up interview on 5/22024 at 10:45 AM the Corporate Director of Nursing stated they could not find any further documentation on nursing competencies for registered nurse #6 and licensed practical nurse #7. During an interview on 5/3/2024 at 12:11 PM the Administrator stated the current staff educator was the Director of Nursing. They had been hired as the Director of Nursing in November 2023. During survey they promoted a Unit Manager into the role of licensed practical nurse/Assistant Director of Nursing and the plan was to get them involved in staff education, which would include doing annual nursing competencies. 10 NYCRR 415.26(c)(1)(iv)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 34459 37516 Based on record review and interview during the recertification survey conducted 4/29/2024-5/3/2024 the facility did not ensure certified nurse aide performance reviews were completed once every 12 months for 2 of 3 certified nurse aides (certified nurse aides #9 and #10) reviewed. Specifically, certified nurse aides #9 and #10 did not have performance reviews documented at least once every 12 months. Findings included: The facility In-Service Training Program, Nurse Aide, revised October 2017, documented the facility would complete a performance review of certified nurse aides at least once every 12 months. Records would be filed in the employee's personnel file or would be maintained by the department supervisor. During a review of personnel files for certified nurse aides #9 and #10 there was no documented evidence of performance reviews completed at least once every 12 months. During an interview on 5/2/2024 at 10:15 AM, the Corporate Director of Nursing stated the certified nurse aide personnel files containing annual performance reviews were kept in the Human Resources office. If they were not there then, they might be in the storage units kept on the facility's grounds and they would look for them. The current facility Director of Nursing was then included in the interview by the Corporate Director of Nursing. The Director of Nursing stated they had only started in the role at the facility in November 2023 and had not done any annual performance reviews for certified nurse aides and they were unsure of where any previous performance reviews were kept. During a follow-up interview on 5/2/2024 at 10:45 AM, the Corporate Director of Nursing stated they could not find the annual performance reviews for certified nurse aides #9 and #10. 10 NYCRR 415.26 (d) (7)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 34459 Based on observation, interview, and record review during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, flavorful, and at appetizing temperatures for 1 of 2 meals sampled (Resident #66). Specifically, food items on 1 of 2 test trays (4/30/2024 lunch meal) were not at acceptable temperatures. Findings include: The facility policy Food Holding Temperatures dated 1/30/2024, documented if temperatures of food were below 140 degrees Fahrenheit, remove them from the steam table and reheat to required minimum preparation temperature of: 165 degrees Fahrenheit - poultry; 150 degrees Fahrenheit - all other meats; 145 degrees Fahrenheit - eggs. The facility policy Temperatures dated 9/2002, documented test trays would be done randomly by the diet technician, registered dietitian, and Food Service Director three days a week and temperature sheets would be kept for sample trays by the diet technician. The policy did not document appropriate food temperatures for meal items when conducting a test tray. During an observation on 4/30/2024 at 11:22 AM, the internal temperatures of lunch food items were measured in the steam table within the main kitchen and included; chicken gravy mix was 190 degrees Fahrenheit, and spinach was 150 degrees Fahrenheit. During an observation on 4/30/2024 at 11:58 AM, the North Unit meal cart left the main kitchen. During an observation on 4/30/2024 at 12:10 PM, a test tray was conducted on a randomly selected North Unit resident's meal tray (Resident #66). A replacement meal tray was requested for the resident. The food was below acceptable palatability ranges. Specifically, the internal temperature of the chicken and gravy mix was measured to be 121 degrees Fahrenheit, and the spinach was measured to be 130 degrees Fahrenheit. During an interview on 4/30/2024 at 12:15 PM, the Food Service Director stated they were surprised foods were measured so low. They wanted foods on resident meal trays to be at least 140 degrees Fahrenheit and they should be warmer for eating. The facility did periodic test trays, and 140 degrees Fahrenheit would be the minimum expected temperature. 10NYCRR 415.14(d)(2)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

34459

Based on observation, record review, and interview during the recertification survey conducted 4/29/2024-5/3/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, the kitchen ventilation hood was unclean and laden with grease and dust buildup; the floor in the walk-in freezer was unclean with food items under shelving storage; and a section of flooring in front of the main dish machine was in disrepair and had unclean water and food debris.

The facility policy Cleaning/sanitation of Kitchen dated 8/2016, documented food service workers and/or cooks were responsible for maintaining a clean environment in the kitchen. All persons were responsible for cleaning up after themselves. The Supervisor Cook, Food Service Manager, diet technician, or dietitian as needed, would ensure this. The Food Service Manager, diet technician, and /or dietitian were responsible party to check on cleaning and maintenance of equipment.

The April 2024 weekly cleaning audits documented all areas of the kitchen were signed off as being done. This included sweeping and mopping under the counter, sweeping and mopping under all equipment, and racks in the cooler. No issues were identified on the audits.

During observations on 4/29/2024 at 10:00 AM, 4/30/2024 at 10:50 AM, and 5/1/2024 at 11:44 AM the main kitchen hood was unclean, dusty, and grease laden. The hood was over the stove top and ovens.

During an interview on 4/29/2024 at 10:00 AM, the Food Service Director stated the hood cleaning vendor came to the facility to clean the hood. They were not sure how often they came in. They stated the kitchen staff did not clean the hood and it should be cleaner.

During an observation on 4/29/2024 at 10:05 AM, the section of flooring under the shelving unit within the walk-in freezer on the left side was unclean with food product on the floor. There were single serve ice cream cups, two hamburger buns, and ice buildup under the shelving rack.

During observations on 4/29/2024 at 10:13 AM, 4/30/2024 at 10:50 AM, and 5/1/2024 at 11:44 AM there was an approximate 3 inch by 12 inch section of broken flooring in front of the commercial dish machine that had food debris and was holding water. The area under this section was in disrepair and was not smooth and cleanable.

During an interview on 4/29/2024 at 10:13 AM, the Food Service Director stated they were not sure how long the floor was broken. Maintenance was made aware. They would like the flooring fixed as it could not be cleaned properly. Dietary staff performed deep cleaning in the kitchen weekly.

During an interview on 4/30/2024 at 2:00 PM, the Director of Facilities stated they were aware of the broken section of kitchen flooring and was waiting on a quote to get replacement flooring. The repairing contractor had not sent the quote back. They were not sure how long the flooring had been broken or when the flooring would be replaced.

NYCRR10 415.14(h)