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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure a clean, comfortable, and homelike environment for two (2) of two (2) resident units (North and South units) and the main front entrance. Specifically, the North and South units had strong urine odors, and unclean walls and floors; and the main front entrance had trash that littered the walkway areas.Findings include: The undated facility policy In-service - Daily Cleaning, documented the objective of a daily cleaning was to ensure cleanliness and safety. Daily cleanings should be performed as follows: trash receptacles should be emptied along with bedside bags, each housekeeper should use good judgement when determining the frequency of trash removal keeping odor control in mind; the housekeep should clean all spots, spills, or scuff marks on vertical surfaces such as walls, doors, and over bed tables; the entire floor must be dry mopped; and the entire floor must be wet mopped, not to forget to mop under the bed, closet floor, behind doors, and the bathroom.The electronic communication from the Administrator documented the facility did not have housekeeping logs and the daily cleaning in-service was the facility housekeeping policy. The Maintenance Logs for both units from 2/13/2026 to 04/03/2026, did not include rooms with scuff marks or rooms in need of painting. Environment observations included:-on 04/01/2026 at approximately 9:45 AM, there was a strong odor of urine in the hallways when entering the units.-on 04/01/2026 at 10:15 AM, the hallway near room [ROOM NUMBER] and the nurse's station had a strong urine odor.-on 04/01/2026 at 10:26 AM, room [ROOM NUMBER] had a strong urine odor.-on 04/01/2026 at approximately 10:30 AM, room [ROOM NUMBER] had peeling paint and the wall behind the bed was in disrepair.-on 04/01/2026 at 10:51 AM, room [ROOM NUMBER] had an unknown spill on the floor.-on 04/01/2026 at 10:55 AM, room [ROOM NUMBER] had food on the floor near the head of the bed with ants on it.-on 04/01/2026 at approximately 11:00 AM, room [ROOM NUMBER] had bed sheets with several rips, and yellow dripping stains down the wall near the side of the bed.-on 04/01/2026 at 11:22 AM, room [ROOM NUMBER] had a strong urine odor.-on 04/01/2026 at 11:31 AM, room [ROOM NUMBER] had black pants, a used towel, and used incontinence briefs on the floor. The resident was not present in the room.-on 04/01/2026 at 2:54 PM and 4:54 PM, room [ROOM NUMBER] had yellow cake like food on the floor near the head of the bed with ants on it. -on 04/02/2026 at 8:11 AM, room [ROOM NUMBER] had yellow cake like food on the floor near the head of the bed with ants on it. -on 04/03/2026 at 8:42 AM, the hallway near rooms [ROOM NUMBERS] had a strong urine odor. During an observation and interview on 04/06/2026 at 1:19 PM, Certified Nurse Aide #5 stated they picked up an extra shift as a housekeeper. The process for cleaning the rooms was to dust high and low, then clean the bathroom. The floors should be mopped every day. They changed the mop three (3) times during cleaning time. They cleaned and tidied the rooms, and then they mopped. Rooms should not have peeling paint or scuff marks, that was not homelike. If they saw things that needed to be fixed, they told Maintenance Worker #6 or wrote it in the maintenance binder at the nurse's station. There should not be any odor of urine in the rooms, hallways, or on the units; that was not home like. The floors were supposed to be mopped daily, so food should not be on the floor for a prolonged period. The aides should help too. Housekeeping staff did not work during the evening. room [ROOM (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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	335208	A. Building B. Wing	04/06/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBER] had scuff marks on the walls at various heights from the resident's bed rubbing on the walls. There were black scuff marks along the heater, that was from the resident wheelchair running along the side of the heater. These items should be reported for repair. They were told the whole unit was getting remodeled, so all that should be fixed with the remodel. The scuff marks were not homelike, and made the heater look dirty and undusted. room [ROOM NUMBER] was a room that required extra cleaning, the resident frequently spilled, and staff needed to be mindful of the room's appearance. There was an area above the heater that did not have paint and a noticeable gap in the dry wall. Certified Nurse Aide #5 stated the imperfections should be fixed with the remodel. During an interview on 04/06/2026 at 2:08 PM, the Director of Housekeeping/Maintenance/Laundry stated they did not have enough staff. They previously did, but one changed roles and the other had either called in or no call/ no showed their last few shifts. Housekeeper #8 was the full time laundry person, and Housekeeper #10 was per diem but would pick up shifts. Housekeeper #8 was on vacation, Housekeeper #9 had not come to work, Housekeeper #10 was working their assigned shifts, and Housekeeper #11 changed roles. The Director was covering the laundry and had certified nurse aides pick up extra shifts to help with cleaning. The housekeepers had a room a day to complete an inspection on, this included the walls, curtains, loose screws, or broken/peeling floors. Staff used the maintenance book to document anything that needed to be fixed. It was not homelike for any location to smell of urine. There should not be any scuff marks on the walls or heaters. The South unit was getting remodeled, but they did not know when. The gap above the heater came from the heater being loose or getting bent from the residents hitting it with their wheelchair. The scuff marks came from the outer rim of the wheelchair. They tried to move rooms around to give the residents more room, but the residents did not like the change. room [ROOM NUMBER] was checked and cleaned one to three times per day. It was checked first thing in the morning, after lunch, and before they left for the day. If there was food on the floor from a meal it should be noticed at the room check after that meal, or first thing in the morning. Housekeeping and Maintenance staff were responsible for checking the outside areas and maintenance did the painting. During an interview on 04/06/2026 at 2:29 PM, Maintenance Worker #6 stated there was a maintenance book at the nurse's station for each unit that they reviewed for work orders or things that needed to be fixed. The person reporting the problem put their initials, and they completed the work, noted what they did, and initialed when completed. They did monthly room checks where they checked the call bells were working and the windows opened only so far for elopement risk. They reviewed the rooms then as part of the monthly preventative maintenance checklist. They were responsible for painting. They knew room [ROOM NUMBER]'s closet doors needed paint and that was on their list to get done. Peeling paint was not homelike. They had someone that came and cleaned up outside. 10 NYCRR 415.5(h)(4)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interviews the facility failed to ensure specific services outside the facility when the facility did not employ a qualified professional to furnish the specific service for one (1) of one (1) resident (Resident #22) reviewed. Specifically, Resident #22 was referred to neurology (nervous system specialist), rheumatology (autoimmune diseases, musculoskeletal disorders, and arthritis specialist), pulmonology (lung specialist), and ophthalmology (eye specialist) and the facility did not follow up on these referrals in a timely manner.Findings include: The facility policy Outside Appointments and Consultations, revised 01/2026, documented the facility would ensure all residents received timely, appropriate, and coordinated care when attending outside appointments or consultations. The facility maintained accountability for continuity of care, resident safety, communication, and follow-up in accordance with state and federal regulations. The physician ordered the consultation and scheduled in collaboration with the resident, responsible party, and interdisciplinary team. Prior to the appointment the facility ensured the resident had necessary clinical documentation, medications, and equipment. Additionally, the facility arranged safe transportation with necessary equipment. Upon return from the appointment the consultation documentation was reviewed, new orders were implemented, the physician was notified of significant findings, and the care plan was updated. When an appointment was missed or refused the reason was documented, the physician and responsible party were notified, and the appointment was rescheduled. Resident #22 had diagnoses including rheumatoid arthritis (autoimmune disease), spinal stenosis (narrowing of spinal canal), respiratory failure, chronic dry eye syndrome, and diabetes. The 03/02/2026 Minimum Data Set assessment documented the resident had intact cognition.The 09/18/2024 Comprehensive Care Plan documented the resident had type two diabetes that was poorly controlled with nerve damage. Interventions included medications, labs, and encourage following ordered diet. The resident had chronic pain related to cervical spine pathology and arthritis with interventions including medication. The resident had communication problems with a visual acuity problem and needed new glasses with interventions including a visual exam. The resident had shortness of breath with interventions to assist with posture and encourage resident when short of breath. The resident used oxygen for diagnosis of respiratory failure and chronic obstructive pulmonary disease. The 1/2/2026 neurology report documented no change at today's visit with next appointment scheduled for 1/13/2026 to review the results of the magnetic resonance imaging. During an interview on 04/06/2026 at 10:30 AM, the neurology office receptionist stated the resident had an appointment on 01/13/2026 and did not show up. They rescheduled the appointment for 02/02/2026 and the resident did not show up for that appointment. The resident did not have any scheduled appointments at this time.There was no documented evidence of nursing progress notes addressing the resident's missed neurology appointments. The resident was scheduled for an appointment with pulmonologist (lung specialist) on 01/08/2026.During an interview on 06/06/2026 the staff at the pulmonology office stated the resident missed their appointment 01/08/2026 and was rescheduled for 01/26/2026 and did not show up for that appointment. There was no documented evidence of nursing progress notes addressing the resident's missed pulmonology appointments. The resident was scheduled for an appointment with rheumatology on 01/15/2026.During an interview on 04/06/2026 at 10:19 AM the rheumatology office could not confirm the resident was seen for that appointment or give any current appointment information.The resident was scheduled for an appointment with Retina Vitreous Surgery (eye specialist) on 01/15/2026.During an interview on 04/06/2026 at 10:16 AM, the Retina Vitreous Surgery office stated the resident did not show up for their appointment on 01/15/2026 and had not rescheduled an appointment. They were last seen in December 2024.There was no documented evidence of nursing progress notes addressing the resident's missed Retina Vitreous Surgery appointments. During an interview on 04/01/2026 at 1:06 (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, Resident #22 stated they saw multiple specialists in the community for several different medical conditions. Often the facility cancelled the appointments due to not having the staff to accompany them or forgetting to coordinate transportation. This had been an issue for several months since the scheduler left employment at the facility. During an interview on 04/03/2026 at 1:44 PM, Registered Nurse #16 stated if a resident required medical treatment from a specialist, the physician would put in a medical order. Medical Records scheduled the appointment and transportation. The resident's family was notified of the appointment date and time. Medical Records sent out a schedule of appointments which was put on the daily assignment sheet. Staff was scheduled and took the resident to and from the appointment. There were times when appointments were cancelled because transportation was not set up or transportation was cancelled because of the weather. During an interview on 04/03/2026 at 1:49 PM, Medical Records Staff #20 stated they were responsible for scheduling appointments and transportation to and from outside appointments. When the physician wanted a resident to see a specialist, the nurse brought them a form with the name of the resident and the specialty being recommended. After making the appointment they scheduled transportation. They brought a folder containing the resident's face sheet, medication list, and appointment information to the unit. Every Friday they brought the upcoming list of scheduled appointments to the unit for the nurses to assign staff. They referred to a binder with appointments organized each month and stated they could not confirm if the residents went to the appointments as they did not get any information from the provider following the appointment. During an interview on 04/06/2026 at 9:33 AM, Licensed Practical Nurse Unit Manager #19 stated when the physician wanted a resident to see a specialist they wrote an order for the consult. Once the order was placed, they discussed it with the resident and gave the request for consultation paperwork to Medical Records Staff #20. Medical Records Staff #20 scheduled the appointment and transportation, made a folder that accompanied the resident to the appointment, and placed the appointment on the schedule. On the day of the appointment the time and specialist were written on the assignment sheet. When the resident returned from the appointment, nursing reviewed the exam findings and recommendations, notified the provider of findings and recommendations, and entered a note about the appointment in a progress note. There was never an appointment that was cancelled for lack of staff. They looked in the computer and could not find documentation about the pulmonary appointment that was scheduled for 01/08/2026, the vascular appointment scheduled for 01/12/2026, the neurology appointment scheduled for 01/13/2026, the rheumatology appointment scheduled for 01/15/2026, the retina vitreous appointment scheduled for 1/20/2026, the pulmonary appointment scheduled for 01/26/2026, or the neurology appointment 02/02/2026. They stated Medical Records #20 was able to review the schedule and could see why Resident #22 did not attend those appointments.During an interview on 04/06/2026 at 9:46 AM, Medical Records #20 stated they were able to confirm they scheduled the following appointments and transportation for the resident, however were not able to locate the findings for the 01/08/2026 pulmonary appointment, the 01/12/2026 vascular appointment, the 01/13/2026 neurology appointment, the 01/15/2026 rheumatology appointment, the 01/20/2026 retina vitreous appointment, the 01/26/2026 pulmonary appointment, or the 02/02/2026 neurology appointment. During an interview on 04/06/2026 at 1:38 PM, the Director of Nursing stated it was important for residents to attend outside specialty appointments to get care that the facility physician could not provide. They were just notified by staff that Resident #22 missed several appointments with specialists since December. They stated the facility did not have medical records staff for three months, which was why appointments got missed. Additionally, transportation cancelled appointments in bad weather. When appointments were cancelled for weather, staff should document that in a progress not and did not. 10 New York Codes Rules and Regulations 415.26(e)

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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. 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 (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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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)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review and interviews, the facility failed to ensure a resident who is fed by enteral means (feeding tube) receives the appropriate treatment and services to prevent complications of enteral feeding for one (1) of one (1) resident (Resident #37) reviewed. Specifically, Resident #37's enteral feeding formula, water flush containers, and tubing were not dated and timed. Findings include: The facility policy Enteral Nutrition, revised 08/2025, did include directions for administering tube feeding and hang life of enteral formulas. Resident #37 had diagnoses including esophageal cancer and gastrostomy (feeding tube) status. The 02/24/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition and required enteral feeding. The Comprehensive Care Plan revised 04/01/2026 documented the resident was at risk for malnutrition related to history of protein calorie malnutrition, schizophrenia, anxiety and depression, history of underweight body mass index, edentulous (having no natural teeth), history of sporadic meal intakes, significant weight loss, increased nutritional needs secondary to cancer diagnoses, low body weight, and low albumin. The resident required a feeding tube for adequate nutrition and hydration, declined scheduled tube feedings at times and other times would push the buttons and stop the tube feeding. Interventions included a regular, pureed consistency, nectar thick liquids diet, may have thin soda and chewing gum; administer tube feeding per physician orders and registered dietitian recommendations; and monitor intakes, weights, labs and skin condition. The 03/31/2026 physician order documented Jevity 1.5 (tube feeding formula) full strength Rate: 75 cubic centimeters per hour x 18 hours twice a day at 2:00 PM and 8:00 AM, continuous. Flush tube with 130 cubic centimeters of water before and after feeding. Administer tube feeding at 2:00 PM and stop at 8:00 AM.During an observation on 04/01/2026 at 12:57 PM, Resident #37 was lying in bed with their tube feeding connected. The formula bottle and flush bags were hung on the pole. The formula bottle was empty with no date, time or staff initials. The flush bag was full and had no date, time or staff initials. The tubing on the bottle and flush bag were not labelled. During an observation on 04/02/2026 at 9:58 AM, the resident was in their wheelchair in the hall. A full bottle of tube feeding formula was hanging on a pole in their room and dated 04/02/2026. The water flush bag was full and hanging on the pole. The flush bag and tubing were not dated or labelled. During an observation on 4/6/2026 at 11:43 AM, the resident's tube feeding formula tubing was connected to the resident and the formula was running at 75 cubic centimeters per hour. The bottle was dated 04/05/2026 and had a volume of 600 milliliters in the bottle. There was no time or staff initials on the bottle. The water flush bag had 500 milliliters in the bag and was dated 04/05/2026. During an interview on 04/06/2026 at 12:03 PM, Registered Nurse #15 stated they were assigned the medication pass for the South Unit. Resident #37 had a tube feeding. The formula bottles were only good for twenty-four (24) hours once opened and should be changed. It was not appropriate for the resident's tube feeding bottle to be dated 04/05/2026. During an interview on 04/06/2026 at 2:25 PM, the Director of Nursing stated tube feeding bottles and tubing should be dated and timed. 10 New York Codes, Rules, Regualtions 415.12(g)(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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews during the facility failed to ensure that residents who required dialysis services (filtration of blood when the kidneys do not work) received such services consistent with professional standards of practice for one (1) of two (2) residents (Resident #10) reviewed. Specifically, Resident #10 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments or consistent documented evidence of communication with the dialysis center. Findings include: The facility policy Dialysis, revised 7/2008, documented residents that received dialysis received interventions to maintain their highest level of functioning. Every dialysis resident had a comprehensive care plan regarding their need for dialysis and residents going out of the building for hemodialysis will take communication sheets allowing for ease of communication between the facilities.Resident #10 had diagnoses including end stage kidney disease with dependence on dialysis. The 01/05/2026 Minimum Data Set assessment documented the resident was cognitively intact, had end stage kidney disease, required dialysis treatments, and did not reject care.The Comprehensive Care Plan initiated 10/17/2024 documented the resident received dialysis on Monday, Wednesday, and Friday. Interventions included monitoring weights before and after dialysis, monitoring vital signs, and thrill pulsation (a purring vibration felt over a fistula signaling high-flow blood) felt at shunt site under fingers. The 08/02/2023 Physician #15 order documented monitor dialysis fistula site every Monday, Wednesday, and Friday.The 09/24/2024 Physician #15 order documented dialysis three times a week on Monday, Wednesday, and Friday.The dialysis and nursing home handoff communication tool documented the resident attended dialysis on 01/02/2026, 01/05/2026, 01/07/2026, 01/09/2026, 01/12/2026, 01/19/2026, 01/21/2026, 01/22/2026, 01/26/2026, 02/02/2026, 02/06/2026, 02/09/2026, 02/16/2026, 02/18/2026, 02/20/2026, 02/25/2026, 03/06/2026, 03/11/2026, 03/23/2026, 03/25/2026, 03/27/2026, and 4/03/2026. Many of the communication sheets were missing the vital signs, pre dialysis weight, and signature of staff sending the resident to dialysis.Dialysis communication sheets were missing for 01/14/2026, 01/16/2026, 01/28/2026, 01/20/2026, 02/04/2026, 02/11/2026, 02/13/2026, 02/23/2026, 02/27/2026, 03/02/2026, 03/04/2026, 03/09/2026, 03/13/2026, 03/16/2026, 03/18/2026, 03/20/2026, 03/30/2026, and 04/01/2026.During an observation and interview on 04/03/2026 at 9:40 AM, Resident #10 was in their room putting on their coat for dialysis. They stated their vital signs had not been taken yet. During an interview on 04/06/2026 at 8:06 AM, Licensed Practical Nurse # 18 stated they were responsible for oversite of residents including administration of medications and completion of treatments. They had one resident that went to dialysis, Resident #10, and dialysis residents did not require any care prior to attending dialysis. Resident #10 was not sent to dialysis with lunch and returned after 2:30 PM after they had left for the day. They stated the resident required an assessment from a registered nurse upon return. During an interview on 04/06/2026 8:30 AM, the Dialysis Center charge nurse stated many times, the resident was sent to dialysis with the communication book, however there was no form in the book, or the form was missing the vital signs, medications, changes or updates in condition, or weight. Durning an interview on 4/06/2026 1:31 PM, Licensed Practical Nurse Unit Manager #19 stated residents that received dialysis had vital signs and their weight taken prior to dialysis which was documented in a communication book. The book was sent with the resident to dialysis to make sure the resident was stable to receive dialysis. When the resident returned from dialysis the registered nurse completed an assessment which was documented in a nursing progress note and on the Medication Administration Record. The assessment was completed to make sure the resident did not have any complications from the dialysis treatment. The fistula (a connection between artery and vein used for dialysis access) was assessed every shift to ensure it was functioning and documented on the Medication Administration Record. During an interview on 04/06/2026 at 1:59 PM, Licensed Practical Nurse #17 stated they normally worked the (continued on next page)

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day shift, however on 04/03/2026, they worked overtime and picked up the evening shift. When a resident returned from dialysis, they were responsible for reviewing the communication book to see what recommendations dialysis was making and if there were any issues during the treatment. They also notified the registered nurse to complete the assessment to ensure the resident was stable after dialysis and the fistula was patent (intact and functioning). The day shift normally left at 2:30 PM but on 04/03/2026 they took over the unit at 2:45 PM. Resident #10 had already returned from dialysis and was assessed by the registered nurse. They did not document they checked the dialysis site on the Medication Administration Record because it was completed by the day shift nurse. During an interview on 04/06/2026 at 2:05 PM, Registered Nurse #16 stated they were the nurse responsible for preparing Resident #10 for dialysis on 04/03/2026. Prior to sending a resident to dialysis, the resident had their vital signs and weight completed and documented in the communication book to ensure they were appropriate for treatment. When the resident returned from dialysis, they reviewed the communication book from dialysis to see if the resident tolerated treatment. The registered nurse should complete an assessment and document the assessment in a progress note. They did not complete the assessment for Resident #10 on 04/03/2026 as the resident had not returned prior to the end of their shift. They did not check the fistula prior to attending dialysis or when the resident returned because the resident had not returned during their shift. They were not sure where the fistula was located because they had not checked it. During an interview on 04/06/2026 at 1:53 PM, The Director of Nursing stated dialysis residents had their weights and vital signs completed prior to every dialysis session. Information was documented in a communication book and sent with the resident to ensure they were stable to receive the dialysis treatment. When the resident returned from dialysis, vital signs were completed, and a weight was obtained. They recently reviewed the communication book for Resident #10 and there was information that was outdated for months. There were missing pages and blank pages that should have been completed. It was important to follow the dialysis procedure to ensure residents were safe before and after treatment. The assessment after dialysis was often not completed because the resident came back at the change of shift. 10 New York Codes, Rules and Regulations 415.12(k)