STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335238	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Valley View Center for Nursing Care and Rehab	2 Glenmere Cove Rd Goshen, NY 10924

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 Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review conducted during the recertification and abbreviated survey (813417) from 7/15/25 - 7/22/25, the facility did not ensure Comprehensive Care Plans were revised to reflect the resident's current condition for 1 of 6 residents (Resident #227) reviewed for Accidents. Specifically, for Resident #227, there was no documented evidence that comprehensive care plans were reviewed and/or revised to include safety interventions recommended by occupational therapy after a 1/18/2024 fall.The findings include:The policy titled Falls Standard of Care and Comprehensive Planning, reviewed 3/2019 documented care plans will be updated in the Electronic Medical Record as soon as the fall investigation is complete.Resident #227's diagnoses included Alzheimer's disease, dependence on renal dialysis, and history of falling.The quarterly Minimum Data Set, dated [DATE] documented Resident #227 was cognitively intact, required a wheelchair for ambulation and was dependent for toileting and transfers. A nursing note dated 1/18/24 documented at 3:45 PM the resident was sitting on the floor in front of a tipped wheelchair. The residents back was against the seat of the wheelchair. No complaints of pain on passive range of motion.An occupational therapy note dated 1/19/24 documented recommend the additional mechanical lift pad only be placed right before outside trips and removed immediately after appointments to reduce Resident 227's risk of sliding forward. Nurse Case Manager made aware of this safety recommendation.There was no documented evidence in the fall care plan to address the 1/19/24 occupational therapy recommendation to place an additional mechanical lift pad right before outside appointments and remove the additional pad immediately after appointments to reduce the risk of falling forward.During an interview on 07/22/2025 at 8:45 AM, Occupational Therapist #9 stated they assessed Resident #227 on 1/19/24 after a 1/18/24 fall. They stated Resident #227 attended out-patient dialysis three times a week and required a mechanical lift for transfers. They stated the dialysis center used a different mechanical lift which required the use of 2 lift pads. They stated the use of an additional pad could have been a factor in Resident #227 sliding out of wheelchair. They stated Resident #227 had poor core strength which could also lead to the resident sliding out of wheelchair. Occupational Therapist #9 stated after the 1/19/24 they recommended removal of one of the mechanical lift pads upon Resident #227's return from dialysis. They stated the safety recommendation was discussed with the unit nursing staff. During an observation of resident care plans, Occupational Therapist #9 stated they were unable to locate the recommended safety care plan intervention. Occupational Therapist #9 stated the Unit Manager Nurse would be responsible for adding the updated care plans safety recommendations to the resident care plan.During an interview on 07/22/2025 at 10:23 AM the Unit Manager Registered Nurse #20 stated they were aware of safety intervention suggested by the occupational therapist status post Resident's #227 fall on 1/18/24. They stated they were not able to locate a care plan update that included the safety intervention of removing the dialysis mechanical lift pad when Resident #227 returned to the building after dialysis appointments. They stated they were responsible for entering any new interventions and should have added it to the care plan. 10 NYCRR 415.11(c)(2)(i-iii)