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	02/03/2026

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during an abbreviated survey (2603474), the facility did not ensure a comprehensive care plan was developed and implemented to maintain the Resident's highest practicable physical, mental, and psychosocial well-being for two (2) of three (3) residents (Resident #1, #4) reviewed for behaviors. Specifically, 1) Resident # 1 had severe cognitive impairment with documented nursing progress notes of wandering behavior, physical and verbal aggression and refusal of cares had no behavior care plan initiated There was no behavior care plan documented in the Electronic Medical Record during the survey. When requested the Facility did not provide a behavioral care plan for the resident. 2) Resident #4 had severe cognitive impairment with inattention and disorganized thinking with documented behaviors verbal/disruptive behaviors no documented evidence of a behavior care plan initiated for the resident.The Findings include:A review of the facility's Comprehensive Care Plan Policy dated 02/1999 and last reviewed 3/2019 documented this plan of care is initiated by the Nursing Care Manager of Nursing Care Supervisor entering into the electronic medical record, for guidance of the Certified Nursing Assistant in regard to bed mobility, transfer, eating, nutrition and toilet use. A care plan is started as soon as possible to address pain, falls, Activities of Daily Living needs, discharge planning and potential development of pressure ulcers. A comprehensive care plan will be developed within (7) days after completion of the comprehensive assessment. The Comprehensive care plan will include measurable goals and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified by, but not limited to, comprehensive assessment. It will depict services that are to be furnished to attain or maintain the resident's highest practicable well-being. The services furnished will meet the professional standards of quality for disciplines involved in providing care. Resident #1 was admitted to the facility with diagnosis that include but not limited to Alzheimer's disease, Type 2 diabetes, and difficulty walking.An annual minimum data set (an assessment tool) dated 8/10/2025 documented the resident had a brief interview of mental status score of 4; indicating severe cognitive impairment with inattention and disorganized thinking with behaviors of delusions and wandering that occurs 1 to 3 days. Wander/elopement alarm coded a zero (0) indicating it was not used.A Review of Resident #1's care plans did not include documented evidence of a behavior care plan for Resident # 1 in the electronic medical record.Review of Certified Nurse aide documentation from 8/1/2025-8/31/2025 documented on 7am- 3pm shift that the resident had a behavior of wandering on 8/11/2025, 8/19/2025 and 8/25/2025. 7 am- 3pm shift documented that Resident # 1 was resistive to care on 8/3/2025, 8/4/2025, 8/7/2025, 8/11/2025, 8/19/2025, 8/21/2025 and 8/15/2025. 3pm-11pm shift documented Resident # 1 has a behavior of wandering on 8/2/2025 and 8/5/2025 and a behavior of resistive to care on 8/1/2025,8/2/2025, 8/5/2025, 8/7/2025, 8/11/2025, 8/17/2025, 8/22/2025 and 8/30/2025. 11pm-7am shift documented Resident # 1 had a behavior of wandering on 8/1/2025,8/3/2025,8/8/2025,8/15/2025, 8/17/2025,8/24/2025 and 8/25/2025 and (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resisted care on 8/1/2025, 8/3/2025, 8/8/2025, 8/9/2025, 8/11/2025, 8/15/2025, 8/17/2025,8/24/2025, 8/25/2025, 8/26/2025, 8/29/2025, 8/30/2025 and 8/31/2025.Review of Nursing progress notes from 8/1/2025-8/31/2025 indicated the resident had behaviors of wandering and aggression on 8/10/2025, 8/11/2025, 8/13/2025, 8/17/2025, 8/27/2025.Review of a Nursing Progress Note dated 8/27/2025 at 2:06 pm documented Resident is with much confusion and agitation this shift. Resident was fixated that staff took their wallet and took it to laundry room, writer called spouse to calm them down; it took resident about an hour to calm down after phone call, but lunch time the resident was fixated that they worked at the hospital last night and started to become agitated and resistive with staff. Writer called wife spouse again and provider. Continue with 30-minute visuals.During an interview with Certified Nurse Aide # 1 on1/7/2025 at 12:52pm they stated Resident # 1 is confused and wanders up and down the hallway and is very repetitive. Resident # 1 sun downs during the 3-11pm shift. Resident # 1 would refuse cares most of the time. If Resident # 1 allows staff to provide care, it takes a while to complete care.During an interview with Licensed Practical Nurse # 1 on 1/8/2025 at 10:31am, they stated Resident # 1 had dementia, acted out with behaviors, was physically aggressive and resisted care. Resident # 1 wanders around in their wheelchair and sometimes can be verbally redirected. Resident 4 was admitted to the facility on and has diagnosis including but not limited to encephalopathy, syncope and collapse, and difficulty in walking.An admission Minimum Data Set, dated [DATE] documented Resident # 4 had a brief interview of mental status score of 1; indicating the resident had severe cognitive impairment with inattention and disorganized thinking. Residents had no behaviors present and were independent with eating and required maximum assistance with toileting, moderate assistance with bed mobility and maximum assistance with transfers.Resident #4's Potential for Elopement care plan dated 1/3/2026 documented interventions that included: Involve in structured activities, assure resident has proper identification including facility phone number and location, 15-minute visuals, Wander guard placed Wander guard # 67, expires in 90 days (4/6/26).Review of the resident physician orders dated 1/3/2026 documented the resident was an Elopement Risk.Review of Certified Nurse aide documentation from 12/17/2025-1/12/2026 documented on 1/7/26 on 7:00 am - 3:00 pm shift, shifts of wandering, verbally abusive behavior, socially inappropriate/disruptive behavior, and resist care. 1/7/26 11:00 pm - 7:00 am verbally abusive behavior, physically abusive behavior, and socially inappropriate/disruptive behavior. 1/8/26 at 3:00 pm - 11:00 pm shift documented wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate/disruptive, and resist care. 1/9/26 11:00 pm - 7:00 am Wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate/disruptive behavior, resists care. 1/11/26 7:00 am - 3:00 pm documented verbally abusive behavior, physically abusive behavior, socially inappropriate/disruptive behavior and resists care. 1/11/26 3:00 pm - 11:00 pm shift documented verbally abusive behavior and resists care.Review of nursing progress notes 12/17/2025-1/12/2026 documented the resident had behaviors on 1/3/2026, 1/6/2026, 1/7/2026, 1/8/2026, and 1/9/2025.Review of a nursing progress note dated 1/6/2026 at 6:51pm documented 3-11pm resident frequently attempting to leave unit, staff monitor for safety.Review of a nursing progress note dated 1/8/2026 at 6:32 am documented Resident # 4 was verbally and physically aggressive with staff when staff trying to assist them with morning cares.There was no documented evidence of a behavior care plan initiated for Resident #4 in the Electronic medical record.During an interview on 1/22/2025 at 9:04 am with Unit Manager # 1, they stated upon admission care plans are initiated and they are updated/revised with any significant changes. Development of a behavior care plan would depend on the type of behavior. If the resident is combative, hitting, spitting, or been physical/verbally aggressive, it would trigger a behavior care plan for the resident. Resident # 1 was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confused and had to be redirected. The resident did not have behaviors. He was difficult with cares if you want to call that a behavior. However, they were private and did not want anyone to see them and that was a challenge. Unit Manager # 1 stated the nurse care manager or Supervisor can update and revise care plans. The floor nurse will report to the manager or supervisor if a care plan needs to be updated, but floor nurses do not update or revise the care plan. Resistance to care can be found in an ADL care plan and it would state that the resident can be non-complainant with care, or it could be noted as a comment under care. Surveyor asked how staff would care for the resident if he resisted care and Unit Manager stated they would wait and give Resident # 1 time and reapproach him for care. The Unit Manager #1 stated per diem staff will care for the residents based on shift reports received, progress notes, and the care plan. Unit Manager #1 stated they heard about the incidents on 8/11/2025 and 8/27/2025 involving Resident #1 when the resident eloped. Unit Manager #1 stated they were not present during the incidents. If they were present, they would have initiated a care plan to address the wandering. Based on the time of the incidents the supervisors should have updated the care plans after the incident. When asked if care plans should be initiated and updated timely Unit Manager #1 responded absolutely. Care plans should be developed and updated to properly care for residents.Unit manager #1 reviewed Resident #1's chart/care plans and acknowledged that there was no behavior care plan. There was also no documentation in the note section of the Activities of Daily Living Care Plan that identified the resident was resistive to care. [10 NYCRR 415.11(c)(1)]

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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 - Minimal harm or potential for 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 record review and interviews during an abbreviated survey (2603474) the facility did not ensure the resident environment was free of accident hazards and that each resident received adequate supervision to prevent elopement for 1(Resident #1) out of 3 residents reviewed for elopement. Specifically, on 8/11/2025 the resident was found off their unit in the kitchen by a dietary staff resident was placed on 15-minute visual checks and identified on the elopement risk assessment to be a high risk for elopement. On 8/27/2025, Resident# 1 was captured on video surveillance exiting the building through the fire exit doors at 3:04pm and returned into the building at 3:15pm.The facility's resident monitoring: visual checks policy dated 1/2010 and reviewed 7/26/2011 documented it is the policy of the facility that all resident's receive appropriate monitoring as the need arise to ensure their safety and protection.Resident #1 was admitted to the facility on [DATE] with diagnosis that include but not limited to Alzheimer's disease, Type 2 diabetes, and difficulty walking.An annual minimum data set (an assessment tool) dated 8/10/2025 documented the resident had a brief interview of mental status score of 4; indicating severe cognitive impairment with inattention and disorganized thinking and behaviors of delusions and wandering that occurs 1 to 3 days. Resident # 1 had no impairments to the upper extremities and impairments on both sides of their lower extremities. Resident uses a wheelchair for locomotion. Resident requires supervision with eating and a maximum assist with toileting. Requires supervision with bed mobility and transfers. Resident is frequently incontinent of urine and always incontinent of bowel. No wander/elopement alarm coded a zero (0); indicating it was not used.Review of an elopement risk assessment dated [DATE] documented Resident #1 had a history of an attempted elopement within the last six months, resident exhibited wandering behavior, resident is cognitively impaired or demonstrated impaired decision making, resident had verbalized they want to go home or other statements indicating desire to leave unit/building, and resident is independently mobile for a total score of 19; which indicated the resident was a high risk for elopement.There was documented evidence of elopement measures/interventions put in place for 15-minute visuals, 30-minute visuals and 1 to 1 monitoring.Review of visual checks documentation indicated there were omissions on 8/12/2025, 8/13/2025 and 8/14/2025. There is no documentation on the day of the incident 8/27/2025 when the resident eloped from 3:00pm-3:30pm.Review of physician orders documented the following:-Order dated 10/28/2024 and last renewed on 8/14/2025 documented Incapable (Resident is incapable of making own decisions)-Order dated 8/11/2025 documented 15 Minute Visuals Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00pm-7:00 am.-Order dated 8/11/2025 Medical Alert: Elopement Risk-Order dated 8/27/2025 documented 1 on 1 Supervision Schedule: Every Day at 7:00 am-3:00 pm; 3:00 pm-11:00 pm; 11:00pm-7:00 amReview of all care plans with no care plan in place to address the behavior of wandering.A review of a potential for elopement care plan dated 3/5/2024 documented the resident had a potential for elopement related to confusion/dementia resulting in attempts to leave on the elevators with interventions dated 3/5/24 provide divisional activity, 1 to 1 to vent feelings, identify concerns, redirect resident, assure resident has proper identification including facility phone number and location, and discuss with family/support persons attempt to leave. Intervention dated 8/11/2025 documented 8/27/2025 1 to 1 ordered for elopement. Interventions dated 8/28/2025 documented wander guard on 8/28/2025- # 52 left ankle with expiration 2/24/2026, and unit changed on 8/28/2025 to H811 B.Review of witness statements from 8/11/2025 documented that staff on glenmere ground were not aware that Resident # 1 was off the unit and found in the kitchen by a dietary volunteer.Review of the video surveillance for 8/27/2025 at 3:04 PM revealed Resident #1 ambulating with the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair out of the exit fire door on the west wing hallway. The resident is able to exit the facility with the wheelchair and seen self-propelling in the wheelchair on the lawn in the back of the building.Review of a Nursing Progress Note dated 8/27/2025 at 2:06 pm documented Resident is with much confusion and agitation this shit. At beginning of shift resident was fixated that staff took their wallet and took it to laundry room, writer called spouse to calm them down; it took resident about an hour to calm down after phone call, but lunch time the resident was fixated that they worked at the hospital last night and started to become agitated and resistive with staff. Writer called wife spouse again and provider. Resident made no attempts to leave unit or go on the elevator this shift, continue with 30-minute visuals.During an interview with the Occupational Therapy Supervisor on 1/7/2026 at 11:30 am they stated on 8/27/2025 when the incident occurred that afternoon they were leaving from work and observed Resident # 1 near the end of the employee parking lot and heard someone approach him which was staff member in social services. They were concerned because they knew the resident should not be outside because they were confused. The staff member from social services approached the resident and ask them if they needed assistance. Occupational Therapy Supervisor stated they called therapy to have a therapist come to main entrance because that staff member was wheeling Resident # 1 up to the main entrance. Therapist met them and reported to the security guard that Resident # 1 was found outside. Therapist brought him back to glenmere ground which was their unit at the time. They know Resident # 1 from working on the unit and knew that Resident # 1 is very confused and should not be alone outside by their self.During an interview with the Director of Nursing on 1/8/2026 at 1:09pm they stated If someone attempts to elope they are evaluated. Interventions that are put in place for the elopement, but it depends on different factors that are involved with determining interventions that are put in place. If a resident eloped off their unit and they have a diagnosis of dementia they may initiate 15-30 minutes with extreme of 1 to 1 until they can make the determination of moving them to the dementia unit. The incident with Resident # 1 occurred at the change of shift and they were made aware approximately 1 hour later that same day. After they were informed that Resident # 1 was found outside they watched the cameras that day as well. It took a while to figure out which door the resident exited out of. Resident went out the west end exit door with his wheelchair and then he went on the sidewalk and roadway and pushed his wheelchair to the front [NAME] in rehab called someone in rehab. The person from rehab brought him inside. She took him to his unit. They do not believe at that moment anyone was aware the resident left the unit. The doors do alarm and did go off at the time of the incident, but they are not sure if the staff heard the alarm because it was change of shift. The staff were congregated near nurse station during change of shift. They believe Resident # 1 had been on visuals for a period and need to look in his chart. Prior to this the resident never made it outside. They cannot remember off the top of their head if the resident ever wanders. An elopement risk assessment is completed after a resident wander. An elopement assessment is completed on admission. They looked into the 8/11/2025 incident and the resident was found by the kitchen area and 15-minute visuals were initiated. Therefore, the visual checks would have been ongoing since 8/11/2025. On 8/27/2025 the resident was switched to 30-minute visuals and once they returned back to their unit they were placed on one to one. Surveyor reviewed visual checks documentation with Director of Nursing. Director of Nursing acknowledged that there was no documentation of completion of 15-minute visuals for Resident # 1 on 8/12/2025, 8/13/2025, and 8/14/2025. Stated if a resident was placed on visuals there also would be an order in Sigma (an electronical medical record).During an interview with the Administrator on 1/9/2025 at 2:15 pm they stated they are trying to think about the incident. The Director of Nursing texted them to inform them that Resident # 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was found outside. The Director of Nursing stayed the day of the incident to make sure Resident # 1 was alright. They know the door did alarm at the time incident when Resident # 1 exited out of the door. Maintenance did check the fire exit after the incident. The incident occurred during change of shift and the resident was placed on one to one. After the incident occurred to prevent a reoccurrence maintenance checked the doors and added cameras in the last month and Resident # 1 was moved upstairs for safety Off the top of their head, they do not recall the amount of time the resident was outside. They believe that training was done but they are not sure they will have to look into the post incident report. They will update the surveyor with the amount of time the resident was outside. Administrator reported that Resident # 1 exited at 3:04pm and returned back into the front door of the building at 3:15 pm. 10 NYCRR 415.12(h)(2)