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 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 observation and interview during the recertification survey conducted from 7/15/25 to 7/25/25, the facility did not ensure that a clean, comfortable, and homelike environment was provided. Specifically, during observation of the Forest Unit, resident rooms [ROOM NUMBERS] had leaking radiator units. Wallpaper throughout the Forest Unit hallways and common areas was torn or missing, ceiling trim had rust stains and a baseboard in room [ROOM NUMBER]B was missing. The Forest Unit shower room had low water pressure and low hot water temperature. During observation of the Town Hall Common area, approximately 25% of the ceiling fluorescent light fixtures were non-functioning. The findings included: The policy titled Resident Living Area Cleaning dated 10/2021 documented all building service workers and building services supervisors will maintain the cleanliness and sanitary conditions within resident rooms, bathrooms, lounge areas, dining rooms and any area that is specifically designated as resident space. The policy titled Maintenance Repair Requisition, revised 8/16/2007, documented all staff members will be responsible for completing maintenance repair requisitions whenever they become aware of any mechanical or equipment damage, failures, or malfunctions or any issues that could impact resident or staff safety. This includes all night lights in resident rooms and stairwell lighting in all buildings. During observation on 07/15/2025 at 12:28 PM in resident room [ROOM NUMBER], a wet towel was on the floor in front of the radiator. The radiator / air conditioning was in off mode. During observation on 07/16/2025 at 09:00 AM in resident room [ROOM NUMBER], a wet sheet was in front of the radiator. The radiator was in off mode.During a Resident Council meeting on 7/16/25 at 11:30 AM residents stated concerns regarding low water pressure on units and hot water taking an extended time to reach a comfortable temperature. They stated these concerns had been discussed during monthly meetings and concerns were reported to certified nurse assistants. They stated Maintenance staff presented to unit/s to address concerns, however due to the buildings being old, the pressure and hot water concerns quickly returned. They stated mixers were added to the shower rooms a few years ago which made the pressure and hot water concerns worse. Resident Council members stated due to hot water taking an extended time to heat up cares were often rushed. Resident Council members stated lighting in the Town Hall common area was not sufficient during activities, which caused difficulty when reading bingo cards and documents. They stated the Town Hall Common area had many non-functioning florescent lights bulbs which had been discussed with the Activities Director during their last meeting.During observation on 07/17/2025 at 11:22 AM and 7/18/25 at 9:06 AM in resident room [ROOM NUMBER], a wet sheet was in front of the radiator. During observation on 07/18/2025 at 9:09 AM in resident room [ROOM NUMBER]B, a baseboard was missing between the wall and radiator.During observation on 07/18/2025 at 9:23 AM a wet towel was on the floor in front of the radiator in room [ROOM NUMBER]. During interview and observation on 7/18/25 at 11:21 AM rooms [ROOM NUMBERS] had leaking radiators. Towels/sheets were in front of the radiator units absorbing the leaking water. The Plant Operations Manager stated radiators were leaking water due to condensation. They stated radiator unit drip pans could become clogged which caused leakage to the floor. They stated they (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were not aware of the leaking radiators and did not recall receiving a maintenance requisition for room [ROOM NUMBER] or room [ROOM NUMBER]. They stated there was no set schedule for radiator maintenance in resident rooms and that the maintenance department relied on unit staff to report concerns. During observation of the Forest Unit hallway there were numerous areas of torn and/or peeling wallpaper, scuffed walls and doors, and areas or rust marks on the ceiling trim. There was a missing baseboard in Resident room [ROOM NUMBER] B between the rear wall and radiator. The Plant Operations Manager stated they were aware of environmental concerns on the unit and plans were upcoming in the future, date unknown, for the unit to be renovated. During observation of the Forest Unit shower and tub/bath basin rooms the shower had low water pressure. The Plant Operations Manager stated shower heads can become clogged which can lead to low water pressure. The shower hot water temperature was measured during observation. A maintenance staff member measured the hot water temperature from 11:37 AM to 11:47 AM. The highest temperature recorded during this time was 91.9 degrees Fahrenheit. The Plant Operations Manager stated they were not aware of Resident Council concerns regarding weak water pressure on units in the [NAME] building and/or hot water taking a long time to become hot. The Plant Operations Manager stated non-emergent environmental / maintenance concerns were reported to the maintenance department through a software program provided on computers in the facility which all staff members could access. Urgent concerns were communicated by telephone at to the Security Department switchboard who would then notify maintenance staff. During observation of the maintenance work order request software program with the Plant Operations Manager, they were unable to locate requests regarding the leaking radiators in rooms [ROOM NUMBERS] or the missing baseboard in room [ROOM NUMBER]A. A work order requesting shower head replacement on the Forest Unit was dated as entered and completed on 7/1/25 During a review of maintenance work order requests provided by the Plant Operations Manager for dates 4/1/25-7/18/25, six work order requests were placed regarding low water pressure in the [NAME] building, including one for the Forest Unit.During an interview and observation on 7/18/25 at 12:07 PM approximately 25% of the fluorescent ceiling lights were not functioning/not illuminated. The Plant Operations Manager stated they were made aware of poor lighting concerns discussed at Resident Council meeting by the Activities Director on July 14, 2025. They stated the concern was discussed with the Administrator during a tour of the area on July 14, 2025, and the Plant Operations Manager and Administrator determined that the current lighting level was adequate, despite approximately 25% of the fluorescent light bulbs being not illuminated/non-functioning. The Plant Operations Manager stated the ceiling is high and a scissor lift, scaffolding or a contractor would be needed to change the fluorescent lightbulbs. They stated they had not contacted a contractor regarding replacing non-functioning fluorescent bulbs and were not aware of any non-functioning florescent light bulbs being changed since they began employment at the facility three years ago. The Plant Operations Manager stated the Town Hall Common area lighting concerns expressed by Resident Council were not considered an emergent situation and facility maintenance staff were currently working on more emergent concerns throughout the facility. They stated they were not aware of a work order being placed regarding nonfunctioning lightbulbs in the area. They stated they had not placed an order for an illumination meter to more accurately determine the lighting in the Town Hall Common area. During interviews on 07/18/25 at 11:49 AM and 7/21/25 at 12:04 PM, Unit Manager Registered Nurse #5 stated they entered a maintenance order for the leaking radiator in room [ROOM NUMBER] earlier this morning when it was reported by a certified nursing assistant. They stated they were not aware that room [ROOM NUMBER] also had a leaking radiator, as staff had not reported any concerns. They stated they conducted environmental rounds every morning. They stated sometimes they just looked inside the door of resident rooms and therefore may not have seen towel/sheet present or a puddle of water from leaks in room [ROOM NUMBER] or 619. They stated when they observed a concern or a concern was reported, they entered a maintenance work order request. Unit Manager Registered Nurse #5 stated they were aware of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	environmental concerns, including low water pressure, radiator leaks and torn/peeling wallpaper throughout the unit. They stated wallpaper replacement and scuff mark cleaning was requested at the last Round Table meeting with the Administrator, Manager and unit heads.10 NYCRR 415.5(h)(2)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during the recertification survey from 7/15/25-7/22/25, the facility did not ensure that staff evaluated the effectiveness of interventions and/or provided immediate interventions to assure the safety of residents to prevent abuse for 1 of 3 residents (Resident #218) reviewed for Abuse and prevent the potential for abuse for 1 of 6 residents (Resident #145) reviewed for Accidents. Specifically, 1. on 4/25/24 Resident # 218 with a history of wandering in/out of other resident rooms was found seated in the bed in Resident #147's room, while Resident #147 stood/masturbated in front of and pushed their penis against the face/mouth of Resident #218. Additionally, after the 4/25/24 incident, staff did not consistently document 15-minute visuals for Resident #218 as per the 4/25/24 incident and accident report/physician order and 2. Resident #145 with a history of wandering was observed on multiple occasion wandering in/out of other resident rooms and sleeping in other resident beds. Subsequently on 07/15/25 Resident #145 entered Resident #134's room and Resident #134 began yelling for Resident #145 to get out of their room. The findings included:A policy titled Preventing Resident Abuse, revised 4/19, documented the facility will not condone any form of resident abuse. The facility's policies and procedures as well as training programs will be monitored in order to assist in preventing resident abuse. 1) Resident #218 had diagnoses including Alzheimer's disease, osteoarthritis, and atrial fibrillation.Resident #218's care plan titled Potential for Abuse Physical/Verbal/Emotional dated 4/6/22 documented potential for abuse as evidenced by cognitive impairment, Alzheimer's, and psychiatric disorders. Interventions included: if abuse is suspected, immediately remove resident(s) from area/person for safety. Immediately contact nurse case manager/nurse supervisor/nursing administrator/administration if allegations of abuse are seen or reported. Frequent visualization of resident to monitor whereabouts and safety. Intervene as needed to ensure the safety of resident(s) and others.Resident #218's quarterly Minimum Data Set, dated [DATE] documented severe cognitive impairment, verbal behaviors towards others/wandering behaviors 1-3 days and use of antidepressant medication. Resident's #147 diagnoses included unspecified dementia, unspecified severity, with agitation, and psychotic disorder with delusions due to known physiological condition and major depressive disorder.Resident #147's admission Minimum Data Set, dated [DATE] documented severe cognitive impairment and verbal behavioral symptoms toward others 1-3 days.Resident #147's care plan titled Potential for Abuse dated 2/16/24 documented the following interventions: behavior notes weekly and as needed, Psychiatry evaluation and treatment as per physician orders, intervene as needed to ensure the safety of resident(s) and others, talk with resident in calm manner, divert attention and take to another location as needed.Resident #218's Care Plan notes dated 3/22/24 documented Resident #218 wanders in/out of other's rooms. Takes other's belongings. Goals and interventions reviewed and ongoing. The 4/5/24 at 10:01 AM Nurse Note documented Resident #218 has a history of ambulating on/off the unit at will, taking random things from random rooms. Redirection effective but short lasting due to dementia.The 4/5/24 at 9:50 PM Nurse Note documented Resident #218 ambulates on/off the unit at will daily. Can be combative with cares. Difficult to redirect. Safety maintained through monitoring.The 4/12/24 at 11:05 AM Nurse Note documented Resident #218 wanders on/off the unit all day going in/out of rooms, often taking belongings that do not belong to them. Can become aggressive when redirected.The 4/19/24 Nurse Note documented Resident #218 self ambulates on/off the unit at will. Continues to wander in/out of other resident rooms and take their personal belongings. Difficult to redirect.There was no documented evidence that Resident #218's care plan was reviewed and/or revised to address ongoing wandering in/out of other resident rooms. The Accident/Incident Report dated 4/25/24 at 5:30 PM documented Registered Nurse #30 was looking for Resident #218 to administer their medications. They found Resident #218 in the room (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Resident #147 who was masturbating into Resident #218's face, standing in front of them. The report documented the physician was notified on 4/26/24 and Resident #218 was assessed by the physician on 4/27/24. No injuries found. Nurse Supervisor notified. Resident #218 was placed on fifteen-minute visuals. Staffing at time of incident was three certified nursing assistants and one nurse. Sexually transmitted disease testing ordered by nurse practitioner with all negative results. The Nurse Progress Note dated 4/25/24 at 6:09 PM, documented: Resident #218 was found sitting on the bed in Resident #147's room. Resident #147 was standing in front of Resident #218 with their penis in their hand, stroking themselves into Resident #218 face. Writer requested Resident #147 to back away from Resident #218 and then immediately removed Resident #218 from the room. They walked Resident #218 to the end of the unit, farthest from the room of Resident #147, and sat Resident #218 down in recliner chair and asked them if they were ok, if they had any pain or discomfort. They denied all and said they were good. They examined Resident #218 for signs / symptoms of injury and found noting and then told the nurse on the Grand unit and notified the Nurse Supervisor. Resident #218's care plan titled Behavior Problem was updated 4/25/24 to include 15-minute visuals.There was no documented evidence on the 15-minute visual logs that 15-minute visuals for Resident #218 were conducted on 4/26/24 3:00 PM-11:00 PM, 4/27/24 11 PM-6:45 AM, 4/28/24 2:30 PM-2:45 PM and 1:15 AM-6:45 AM, and on 4/29/24 12:15 PM-12:45 PM.The Nurse Progress Note dated 4/28/24 at 2:20 PM documented Resident #218 was in the [NAME] Unit sunroom. Resident #147 was also in the sunroom with a sitter. Resident #218 was redirected off of the unit by staff/sitter. During interview on 07/21/2025 at 11:52 AM Unit Manager Registered Nurse # 9 stated when the unit has four certified nurse assistants on duty during the day shift, there is sufficient redirection. Unit Manager Registered Nurse #9 stated there are day shifts when only three certified nurse assistants are present during the day shift. Unit Manager Registered Nurse #9 stated the unit has many residents who wander and redirection for all residents can be difficult. They stated many of the unit residents move quickly and constantly go in and out of other residents' rooms. They stated a request for additional staffing has been discussed with the Supervisor. During an interview on 07/21/2025 at 4:58 PM, the Director of Nursing stated residents on the dementia unit wander frequently and were observed and redirected by the unit staff. The Director of Nursing stated that to prevent further incidents between Residents #147 and #218, they asked certified nurse assistants to increase unit rounds and Resident #218 was no longer allowed on the same unit as Resident #147.During an interview on 7/22/25 at 1:23 PM, Registered Nurse #30 stated they remembered the incident and immediately separated the residents. They assessed Resident #218 for fear or anxiety. No change in resident status. Registered Nurse #30 stated they called the Director of Nursing immediately because they were aware that incidents involving abuse needed to be reported immediately.During an interview on 07/22/2025 at 4:41 PM the Administrator stated Resident #147 is territorial of their area and can be difficult to manage. 2) Resident #145's diagnoses included unspecified dementia with other behavioral disturbance, type II diabetes mellitus, and psychotic disorder with hallucinations.Resident #145's care plan titled Behavioral Problems dated 9/25/24 documented Alzheimer's, as evidenced by physically abusive behavior, socially inappropriate or disruptive behaviors, rummaging through other's belongings, moves bowels on the floor, wandering. Interventions included monitor behavior to assist in determining cause: times, places, situations, activity underway, noise levels, persons involved, length of period of upset, activities. Modify environment, situations, and / or treatment to minimize episodes as needed. Anticipate needs. Activities. Discuss behavior with staff, care plan team and resident if appropriate.The behavior notes dated 6/17/25 to 7/17/25 documented Resident #145 wanders into peers' rooms and sleeps in their beds, continue to redirect. Resident #145 found sleeping in beds of other residents on 6/21/25, 6/23/25, 6/26/25, 6/27/25, 7/3/25, 7/7/25, 7/8/25, 7/9/15 7/14/25, and 7/15/25.Resident #145's quarterly Minimum Data Set, dated [DATE] documented severe cognitive impairment, wandering behaviors, and physical, verbal, and other behavioral symptoms towards others.During an interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and observation on 07/15/2025 at 11:00 AM. Resident #145 was observed entering Resident #134's room. Resident #134 was present in the room and yelled for Resident #145 to get out of room. Resident #134 stated Resident #145 frequently wandered into their room and attempted to sleep in their roommate's bed. Resident #145 left the room when Resident #134 yelled to get out. Resident #145 returned to a chair outside the day room. Staff were not present in the unit hallway at the time of observation.During an observation on 07/15/2025 at 12:36 PM Resident #145 was observed entering Resident #61 and Resident #205's room and using the bathroom. Staff did not observe Resident #145 entering Resident #61 and Resident #205's room, as they were present in the day room and at the lower end of the unit. During an observation on 07/15/2025 at 1:55 PM Resident #145 was observed sleeping in Resident #210's bed. Staff were present in the dining room assisting with lunch and did not observe Resident #145's wandering or provide redirection. During interviews on 07/18/2025 at 10:06 AM Unit Manager Registered Nurse #9, stated the unit usually had two resident activities daily, depending on activities staff availability. They stated Resident #145 is a wanderer and frequently wandered into other residents' rooms to sleep in empty beds. They stated Resident #145 could become agitated when woken up. They stated Resident #145 did not attempt to sleep in an occupied bed. Unit Manager Registered Nurse # 9 stated when the unit has four certified nurse assistants on duty during the day shift, there is sufficient redirection. They stated there are days shifts when only three certified nurse assistants are present during the day shift. Unit Manager Registered Nurse #9 stated Resident #145 did not attend morning activities and preferred to sleep after breakfast. They stated Resident #145 would participate in afternoon activities at times, especially if music was involved. They stated Resident #145 preferred to stay in the unit hallway and did not frequently sit in the day room. During an interview on 07/22/2025 at 9:26 AM, Activities Specialist #28 stated Resident #145 occasionally participated in afternoon activities and enjoyed music and exercise. They stated Resident #145 did not usually attend morning activities as they preferred to sleep after breakfast. They stated Resident #145 was cooperative during activities. They stated Resident #145 often participated in afternoon activities 3-4 times a week and if they observed weeks when Resident #145's attendance was low, individualized activities were attempted. During an observation and brief interview on 07/22/2025 at 9:37 AM Resident #145 was observed sleeping in Resident # 31's room. There was no staff present in the unit hallway to provide Resident #145 with supervision or redirection. Unit Manager Registered Nurse #9 stated staff was not present to provide redirection in unit hallways due to most residents being in morning activity and certified nurse assistants were providing cares. They stated the unit started shift with three certified nurse assistants assigned and they had to request a fourth certified nurse assistant be sent to the unit. They stated they could only try to supervise all the residents. During an interview on 07/22/2025 at 9:49 AM Certified Nurse Assistant #29 stated Resident #145 frequently wandered into other residents' rooms. They stated Resident #145 frequently attended afternoon activities and did not attend morning activities. They stated they could adequately supervise residents on the unit. 10 NYCRR 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility did not ensure that they initiated and completed a thorough investigation of alleged violations of abuse to prevent further potential abuse for one of three residents (#218) reviewed for abuse and three of four residents (#19, #99 and #25) reviewed for resident rights. Specifically, 1) on 4/25/24 at 4:30 PM, Registered Nurse # 30 was looking for Resident #218 and located them in Resident's #147's room. Resident #147 was standing in front of Resident #218 masturbating in their face. There was no documented evidence the Accident/Incident Report was completed until 6/19/24 and 2) the facility did not complete an investigation after Resident #19 reported a missing ring and 3) Resident #99 reported a missing purse. Additionally, there was no documented evidence that a thorough complete investigation was conducted after Resident # 25 reported a missing wallet. The findings included: The policy titled Resident Abuse and Neglect revised 4/19, documented it is the facility policy that all reports of abuse, mistreatment, neglect, exploitation and injuries of unknown origin be promptly and thoroughly investigated by facility management. The policy titled Accident and Incident Reporting reviewed 7/23, documented it is the facility policy that an Accident / Incident report will be initiated and completed for all accident/incidents. To perform a systematic review of all resident accidents/incidents and/or injuries in order to determine potential hazards and a corrective action to maintain a safe and secure environment. The Policy and Procedure titled Grievances, dated 6/19, documented the facility will promptly resolve all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The facility grievance process will be overseen by the Director of Social Services, who will be. Responsible for receiving and tracking grievances. The grievance process is intended to support. Each residence has rights. To voice grievances. Examples of care management include funds, lost clothing, or violation of rights. 1) Resident #218 had diagnoses including Alzheimer's disease, osteoarthritis, and atrial fibrillation. The annual Minimum Data Assessment, dated 4/27/24, documented Resident #218 had severely impaired cognition, required set up for eating, was dependent with toileting and required partial to moderate assist with all other activities of daily living. The care plan titled Potential for Abuse Physical/Verbal/Emotional dated 4/6/22 documented potential for abuse as evidenced by cognitive impairment, Azheimers and psychiatric disorders. If abuse is suspected, immediately remove resident(s) from area/person for safety. Immediately contact nurse case manager/nurse supervisor/nursing administrator/administration if allegations of abuse are seen or reported. Frequent visualization of resident to monitor whereabouts and safety. Intervene as needed to ensure the safety of resident(s) and others. The Resident-to-Resident Incident Report dated 4/25/24 at 5:30 PM for Resident #218, stated Registered Nurse #30 was looking for Resident #218 to administer their medications They found the resident in the room with a male resident who was masturbating into Resident #218's face. The physician was notified on 4/26/24 and the resident was seen by the physician on 4/27/24. No injuries (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	found. Nurse Supervisor notified. The resident placed on fifteen-minute visuals. There were three certified nursing assistants and one nurse staffed at the time. Sexually transmitted disease testing ordered by the nurse practitioner with all negative results. The supervisory review section, dated 6/18/24, documented Resident #218 was found with Resident #147's penis in their mouth. Immediately separated by staff and taken off unit. Staff Nurse/Nurse Supervisor spoke with the resident who showed no signs or symptoms of distress/fearfulness. Hall monitor aware to keep Resident #218 off the Forest unit/away from #Resident #147. The Assistant Director of Nursing review section, signed 6/19/24, documented the incident was not the result of abuse/mistreatment/neglect. Explanation was documented as accidental. Seen by the Nurse Practitioner. Urines for sexually transmitted diseases ordered. All negative. Resident was monitored for any changes in behavior. The Accident/Incident Report was initialed by the Nurse Manager (dated 6/14/24), Director of Nursing (dated 6/19/24) and Medial Director (dated 6/21/24). There was no Administrator signature or date. A statement obtained from Certified Nursing Assistant #31 was dated 4/25/24. A statement obtained from Certified Nursing Assistant #32 was dated 5/23/24. A statement obtained from Certified Nursing Assistant #33 was dated 5/23/24. During an interview on 7/22/25 at 1:23PM, Registered Nurse #30 stated they remembered the incident and immediately separated the residents. They assessed Resident #218 for fear or anxiety. They stated there was no change in resident status. Registered Nurse #30 stated they called the Director of Nursing immediately. During interviews on 07/21/2025 at 4:54 PM and 7/22/25 at 1:57 PM the Assistant Director of Nursing stated they were aware of the incident when it occurred and that the Unit Manager was responsible for the investigation, which was started right away. They stated they did not know why the accident and incident report was not signed as reviewed by the Administrator or why the report/investigation review was not completed until 6/19/24. They stated they were aware that certified nursing assistant witness statements were not obtained until May 23 and 24, 2024. They stated they did consider the incident abuse at the time. During an interview on 07/21/2025 at 4:58 PM, the Director of Nursing stated the incident report/investigation would have been reviewed around the time of occurrence either directly/verbally with the Administrator or at the facility's weekly round table meetings. They stated they were not able to remember exactly when the incident was reported to Administrator. They stated they did not know why the accident and incident report was not signed as reviewed by the Administrator or why the report/investigation review was not completed until 6/19/24. They stated the witness statements may not have been able to be completed immediately due to the certified nurse assistants not working at the facility again until May 23 and May 24, 2024, but they were not sure. They stated they were unable to determine if the incident was considered abuse. During an interview on 07/22/2025 at 4:41 PM, the Administrator stated they did not recall this specific accident and/or incident. They stated they did not recall verbally discussing the accident/incident with the Director of Nursing or other staff, The Administrator stated they did not receive an Accident/Incident Report to review and sign. 2) Resident #19 had diagnoses that included anxiety, hypertension, and depression. The Quarterly Minimum Data Set, dated [DATE] documented Resident #19 had intact cognition and no behaviors. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/2025 at 11:12 AM, Resident # 19 stated they were missing their Dottie ring. They stated it was lost less than a year ago. They stated they informed Registered Nurse Unit Manager #18, but they did not hear anything further about it. The 2024 and 2025 Facility Missing Items logs had no documented evidence of missing items. During an interview on 7/18/25 at 2:45 PM Registered Nurse Unit Manager #18 stated Resident#19 did report a missing ring sometime during the last year, the Dorothy ring. They stated when a resident was missing an item, they were to fill out a missing item form which was on green paper and give that form to administration. They stated they could not recall if they completed a missing item form for this item. They stated it was the Unit Manager's responsibility to complete the form. During an interview on 7/22/2025 at 2:11 PM, the Director of Social Services stated the Nurse Care Manager was responsible for completing the missing item form which was on a paper and different from the grievance form. After completing the form, it should be given to administration and then the Administrator should sign off once the investigation was completed. They stated they were not currently aware of any missing items. During an interview on 07/22/2025 at 02:41 PM, Registered Nurse Unit Manager #7 stated that they completed a green missing item form if a resident reported a missing item. They would also collect statements from staff and then provide the form and statements to the Assistant Director of Nursing for review. They stated the last item reported missing was Resident #99's purse. They stated they completed the process as described but the item was still missing. During an interview on 07/22/2025 at 02:59 PM, the Assistant Director of Nursing stated when an item is lost, the nurse completes the missing item form and gathers statements from staff. The nurse gives those documents to the Assistant Director of Nursing, and they will review them. They then communicate their findings to the Administrator and the Administrator will decide how to proceed. They stated the decisions could be police notification, replacement of the missing property or monetary reimbursement for the value of the item. During an interview on 07/22/2025 at 03:13 PM, the Administrator stated that the missing item form had been replaced. There is a new policy for missing items which is not being followed. They stated once a missing item is reported an investigation should be conducted and the resident should be informed of the status of the investigation. They stated the facility could reimburse residents for lost items and law enforcement may be notified 3) Resident #99 had diagnoses of Chronic Atrial Fibrillation, Presence of a Pacemaker, and Type 2 Diabetes. The 1/12/25 annual Minimum Data Set documented, Resident #99 was cognitively intact. There was no documented evidence in the Concern Log for 2023, 2024, and 2025 to indicate Resident # 99 had missing items. During an observation on 7/22/25 at 4:35 PM, Resident #99 had a locked drawer, which is functional. During an interview on July 22, 2025, at 4:00 PM, Resident #99 stated that a purse had been missing since before Easter. They stated they left the room at approximately 2:00 PM for an event that (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concluded at 4:00 PM and upon returning to the room, the resident noticed their purse was missing from the bed area. A request was made to speak to the supervisor, who responded along with the nurse care manager. They stated the incident was also mentioned in the monthly resident council meetings. They stated the missing purse contained the resident's grandmother's rosary beads ([AGE] years old), a $20 bill, a debit card, and a pacemaker card. During an interview with the Social Worker on 7/22/2025 at 2:11 PM, they stated the facility resident's missing items process is not with Social Services. They stated nursing staff oversees the process. During an interview with Nurse Manager r#7 on 7/22/25 at 4:10 PM, they stated they were aware of the missing purse. They stated per protocol they filled out the form and took it to the administrator's office. They stated they did not follow up. During an interview with the Administrator on 7/22/25 at 4:20 PM, they stated they were unaware of Resident #99's missing purse and/or wallet. 10NYCRR 415.4(b)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview conducted during the recertification survey from 7/15/2025 to 7/22/2025, the facility did not ensure proper storage in accordance with professional standards for food safety. Specifically, multiple containers of unmarked, undated food were observed in facility refrigerators and freezers, multiple containers of food were in the dry storage area without a date to indicate when they had been opened, a kitchen staff's personal drink item was observed in a refrigerator which stored resident foods, and a malodor was present in the meat refrigerator where food was stored.The findings include:The policy titled Refrigerator Non-Medication Cleaning and Monitoring last revised on 03/2025, documented all food in refrigerators will be monitored for proper food labeling. The policy titled Infection Control/Handling Leftovers last revised on 08/2020, documented all unused food that has not been served, may be used within 48 hours from the time of preparation. All food shall be dated.During observation of the kitchen and interview on 07/15/2025 at 9:57 AM, the dairy refrigerator had two bags of liquid eggs which were unlabeled, undated and not in their original container. The meat freezer had one container of french toast, one bag of round waffles, one bag of meatballs, and one bag of chicken tenders which were unlabeled/undated and not in their original container. Mobile #2 refrigerator had sandwiches which were unlabeled/not properly dated and there was an unlabeled and undated half liter container of [NAME] Donuts iced drink which belonged to kitchen staff. The Food Service Supervisor identified the food in each of the containers and bags and stated the items were not labeled or dated properly.During observation of the dry storage area and interview on 07/15/2025 at 11:16 AM there was one bag of open graham crackers, one bag of open classic pasta, one bag of open spaghetti noodles, one gallon of open vegetable oil, one gallon of open vanilla syrup, one quart of open brown/season mix, and one box of open baking soda that did not contain a date to indicate when they had been opened. The Acting Dietary Director stated the items were not dated when they were opened. They also stated kitchen staff would need to remove their personal drink item from the refrigerator that was being used for resident/s food. During observation on 7/22/2025, at 12:20 PM, a malodor was observed in the meat refrigerator where food was stored. During an interview at the time of finding, the Acting Dietary Director confirmed there was an odor and stated that it could not be determined where the order was coming from. During a subsequent interview on 07/22/2025 at approximately 12:30 PM, the maintenance supervisor confirmed the odor and stated the compressor would be assessed to determine where the odor may be coming from.10 NYCRR 415.14 (h)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview conducted during the recertification survey from 7/15/25 to 7/22/25, the facility did not ensure all mechanical and electrical equipment was in safe operating condition. Specifically, water was observed leaking from the kitchen dishwasher which allowed standing water to be present on the floor in and around the dishwasher. The findings include:During observation of the kitchen and interview on 07/21/2025 at 1:46 PM the dishwasher was leaking water which allowed standing water to be present on the floor in and around the dishwasher. The Acting Dietary Director stated the standing water had been present for some time and they were working with maintenance to see if they should install a new drain or provide a path in the floor for the water to flow. During an interview of 7/22/2025 at 11:01 AM the Maintenance Supervisor stated the facility had a computer program for reporting maintenance issues. After a maintenance issue is entered, maintenance staff evaluate the problem and see what is needed to repair the equipment. They stated the dishwasher was leaking water in a different area and the water was not able to flow into the floor drain as designed. They stated the floor drain was obstructed by debris and standing water around the dishwasher had been a problem in the past. They stated maintenance had not been able to repair the water leak or clean the floor drain. They stated maintenance would need to contact an outside contractor to repair the leak and clean the floor drain to prevent further standing water.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the Recertification Survey from 7/15/2025-7/22/2025, the facility did not ensure reasonable accommodation of resident needs and preferences. Specifically, one of four residents (Resident #187) reviewed for accommodation of needs and one of five residents (Resident #119) reviewed for call devices, were observed on multiple occasions with the call bell device not within the resident's reach. The findings include:Resident #187 had diagnoses including but not limited to cerebrovascular accident, peripheral vascular disease, and coronary artery disease. The Annual Minimum Data Set, dated [DATE] documented Resident #187 had moderately impaired cognition and received maximum and/or dependent staff assistance for most activities of daily living.Resident #187's Fall Care Plan initiated 8/19/2019 documented the call bell must remain within the residents reach and ensure prompt staff response. During an observation and interview on 7/16/2025 at 10:06 AM Resident #187 was observed sitting in a wheelchair in their room, their call bell was observed across the room and not within their reach. Resident #187 stated their call bell was often out of reach. During an observation on 7/18/25 at 8:37 AM Resident #187 was observed sitting in a wheelchair in their room with a bedside table in front of them. Resident #187's call bell was on the bed behind the resident and not within their reach. Resident #119 had diagnoses including but not limited to anoxic brain damage, anxiety disorder, and unspecified epilepsy.The Annual Minimum Data Set, dated [DATE] documented Resident #119 had severely impaired cognition and was dependent on staff for assistance with activities of daily living.Resident #119's Fall Care Plan initiated 3/22/2016 documented the call bell must remain within the residents reach and ensure prompt staff response. During an observation on 7/15/2025 at 10:47 AM Resident #119 was observed in bed. Resident #119's call bell was hanging on the wall and was not within their reach. During an observation on 7/17/2025 at 10:58 AM Resident #119 was observed in bed. Resident #119's call bell was wrapped on the lower part of the bed rail and was not within their reach. During an observation on 7/18/25 at 12:45 PM, Resident #119 was observed in bed. Resident #119's call bell was hanging on the wall and not within their reach. During an interview on 7/21/2025 at 1:12 PM Registered Nurse Unit Manager #20 stated Resident #119 was not always able to use their call bell, as their ability varied. They stated on 7/20/25 there was a progress note that documented Resident #119 rang for assistance, so they could use it at times. They stated call bells should be accessible to all residents even if their capacity was limited. NYCRR 415.5 (e)(1)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during a recertification survey the facility did not ensure each resident was free from misappropriation of resident property for two of four residents (#19, and #99) reviewed for resident rights. Specifically, 1) Resident #19 reported a missing ring and 2) Resident #99 reported a missing purse which contained rosary beads, a twenty dollar bill, debit card and pacemaker card. The findings include: The Policy and Procedure titled Grievances, dated 6/19, documented the facility will promptly resolve all grievances, keeping the resident and resident representative informed throughout the investigation and resolution process. The facility grievance process will be overseen by the Director of Social Services, who will be. Responsible for receiving and tracking grievances. The grievance process is intended to support. Each residence has rights. To voice grievances. Examples of care management include funds, lost clothing, or violation of rights. 1) Resident #19 had diagnoses that included anxiety, hypertension, and depression. The Quarterly Minimum Data Set, dated [DATE] documented Resident #19 had intact cognition and no behaviors. During an interview on 07/16/2025 at 11:12 AM, Resident # 19 stated they were missing their Dottie ring. They stated it was lost less than a year ago. They stated they informed Registered Nurse Unit Manager #18, but they did not hear anything further about it. The 2024 and 2025 Facility Missing Items logs had no documented evidence of missing items. During an interview on 7/18/25 at 2:45 PM Registered Nurse Unit Manager #18 stated Resident#19 did report a missing ring sometime during the last year, the Dorothy ring. They stated when a resident was missing an item, they were to fill out a missing item form which was on green paper and give that form to administration. They could not recall if they completed a missing item form for this item. They stated it was the Unit Manager's responsibility to complete the form. During an interview on 07/22/2025 at 02:59 PM, the Assistant Director of Nursing stated when an item is lost, the nurse completes the missing item form and gathers statements from staff. The nurse gives those documents to the Assistant Director of Nursing, and they will review them. They then communicate their findings to the Administrator and the Administrator will decide how to proceed. They stated the decisions could be police notification, replacement of the missing property or monetary reimbursement for the value of the item. During an interview on 07/22/2025 at 03:13 PM, the Administrator stated that the missing item form had been replaced. There is a new policy for missing items which is not being followed. They stated once a missing item is reported an investigation should be conducted and the resident should be informed of the status of the investigation. They stated the facility could reimburse residents for lost items and law enforcement may be notified 2) Resident #99 had diagnoses of Chronic Atrial Fibrillation, Presence of a Pacemaker, and Type 2 Diabetes. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/12/25 annual Minimum Data Set documented, Resident #99 was cognitively intact. There was no documented evidence in the Concern Log for 2023, 2024, and 2025 to indicate Resident # 99 had missing items. During an observation on 7/22/25 at 4:35 PM, Resident #99 had a locked drawer, which is functional. During an interview on July 22, 2025, at 4:00 PM, Resident #99 stated that a purse had been missing since before Easter. They stated they left the room at approximately 2:00 PM for an event that concluded at 4:00 PM and upon returning to the room, the resident noticed their purse was missing from the bed area. A request was made to speak to the supervisor, who responded along with the nurse care manager. They stated the incident was also mentioned in the monthly resident council meetings. They stated the missing purse contained the resident's grandmother's rosary beads ([AGE] years old), a $20 bill, a debit card, and a pacemaker card. During an interview with Nurse Manager r#7 on 7/22/25 at 4:10 PM, they stated they were aware of the missing purse. They stated per protocol they filled out the form and took it to the administrator's office. They stated they did not follow up. During an interview with the Administrator on 7/22/25 at 4:20 PM, they stated they were unaware of Resident #99's missing purse and/or wallet. NYCRR 415.4 (b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review conducted during the recertification from 7/15/25 to 7/22/25, the facility did not ensure all alleged violations of abuse were reported immediately, but not later than 2 hours to the state survey agency for 1 of 3 residents reviewed for Abuse (Resident #218). Specifically, there was no documented evidence that an allegation of abuse was reported to the facility Administrator or to the state survey agency after a 4/25/24 incident where Resident # 218 with a history of wandering in/out of other resident rooms was found seated in the bed in Resident #147's room, while Resident #147 stood and masturbated in front of Resident #218.The findings included:The policy titled Resident Abuse and Neglect, revised 4/19, documented it is the facility policy that all reports of abuse, mistreatment, neglect, exploitation and injuries of unknown origin be promptly and thoroughly investigated by facility management. NOTE: Federal Regulations (42 CFR 483.13) and New York State (NYS) Regulations (10 NYCRR 415.4) require the reporting of alleged violations of abuse, mistreatment, exploitation and neglect, including injuries of unknown origin, immediately to the Facility Administrator/designee.Resident #218 had diagnoses including Alzheimer's disease, osteoarthritis, and atrial fibrillation.The annual Minimum Data Assessment, dated 4/27/24, documented Resident #218 had severely impaired cognition.The Resident-to-Resident Incident Report dated 4/25/24 at 5:30 PM for Resident #218, stated Registered Nurse #30 was looking for Resident #218 to administer their medications. They found the resident in the room with a male resident who was masturbating into Resident #218's face, standing in front of her. Nurse supervisor notified.During an interview on 7/22/25 at 1:23PM, Registered Nurse #30 stated they called the Director of Nursing immediately because they were aware that incidents involving abuse needed to be reported immediately.During interviews on 07/21/2025 at 4:54 PM and 7/22/25 at 1:57PM the Assistant Director of Nursing stated the incident was not reported to the New York State Department of Health. They stated the Director or Assistant Director of Nursing would have been responsible for reporting. They stated they did consider the incident abuse at the time.During an interview on 07/21/2025 at 4:58 PM, the Director of Nursing stated the incident was not reported to the New York State Department of Health. During an interview on 07/22/2025 at 4:41 PM, the Administrator stated they did not recall this specific accident and/or incident. They stated they did not recall discussing the accident/incident with staff and did not recall reporting to the New York State Department of Health. 10 NYCRR 415.4

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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. Based on observation, interview and record review conducted during a recertification survey, from 7/15/2025-7/22/2025 the facility did not ensure that comprehensive person-centered care plans were developed and/or implemented for each resident to meet the resident's medical and/or nursing needs for 1 of 4 residents (#214) reviewed for range of motion. Specifically, for Resident #214 with muscle weakness a care plan was not developed to address left-hand contracture and/or the use of a left-hand roll as per occupational therapy recommendation The findings includeResident # 214 had diagnoses which included Dementia. A Quarterly Minimum Data Set (assessment tool) dated 6/15/25 documented Resident #214 had severely impaired cognition, no functional limitation in range of motion, and received substantial/maximal assistance with all other activities of daily livingThe Occupational Therapy Discharge Note dated 6/20/2025, documented staff/caregivers were educated and instructed on the use of a left upper extremity handroll schedule, range of motion, hygiene, and skin checks for irritation. During observation on 07/15/2025 at 2:02 PM, 7/16/2025 at 12:20 PM, 7/17/2025 at 3:20 PM, and 7/18/2025 at 9:03 AM Resident #214 was resting in their wheelchair. Their left hand was contracted and did not have a hand roll in place. There was no documented evidence that a care plan was developed, and physician orders were obtained to address contracture management and the use of a left-hand roll as per Occupational Therapy recommendation.During an interview on 7/18/2025 at 9:05 AM Licensed Practical Nurse #6 stated the resident had a contracted left hand and had been receiving therapy. They stated they did not know the outcome of therapy. They stated if the resident needed an intervention such as a hand roll it should have been care planned.During an interview on 7/18/25 at 10:15 AM Registered Nurse Unit Manager #5 stated when therapy recommended the hand roll and educated the staff, an order should have been placed, a care plan should have been developed, and it should have been documented on the Certified Nurse Aide Assignment Instructions. They stated they were only covering the unit and did not know why these things did not occur. They stated the Licensed Practical Nurse called them earlier this morning regarding the resident's hand being contracted and they contacted therapy. During an interview on 7/18/25 10:29 AM the Assistant Director of Nursing stated if Occupational Therapy recommended a hand roll was to be worn, it was the Unit Managers responsibility to develop a care plan for contracture management and add the use of the hand roll to the Certified Nurse Aide Assignment Instructions. 10 NYCRR 415.11(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the Recertification Survey from 7/15/2025-7/22/2025, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one of three residents (#6) reviewed for mood and behavior and one of four residents (#171) reviewed for positioning. Specifically, 1) Resident #6 did not receive follow up psychiatric services as ordered and recommended by the physician and 2) Resident #171 was observed seated in their wheelchair with their legs/feet unsupported and dangling above the footrests.The findings include: 1) Resident #6 had diagnoses including but not limited to unspecified dementia, psychotic disorder, and anxiety disorder. The physician order dated 10/16/2024 documented psychiatric consultation in house follow up in one-month last visit 10/16/2024. There was no documented evidence of a psychiatric follow up after the 10/16/2024 consultation. The care plan titled Psychotropic Drug Use with a 3/25/2024 revision date documented continue psychiatric medications and follow up with psychiatry services. The physician order dated 4/3/2025 documented psychology consultation in house for possible gradual dose reduction, evaluate effectiveness. There was no documented evidence of a psychology consultation as per the 4/3/2025 physician order. The Annual Minimum Data Set (assessment tool) dated 4/27/2025 documented Resident #6 had severely impaired cognition, no behaviors, and received antipsychotic medication. The physician order renewal 7/14/2025 documented Xanax 0.25 milligrams every week prior to baths for anxiety disorder and Rexulti 0.5 milligrams once daily for major depressive disorder. During an observation on 07/17/2025 at 11:03 AM, Resident #6 was sitting in the common area on the unit with other residents. They hit and pushed all water containers and cups on the table in front of them onto the floor. During an observation on 7/21/25 at 10:15 AM, Resident #6 was in their wheelchair in the room alone facing the television which was on. They stated, help me, help me, give me a kiss. Resident #6 was redirected and reassured. During an interview on 7/21/25 at 10:25 AM, Covering Registered Nurse Unit Manager #24 stated the last psychiatry consultation was on 10/16/2024. They stated they were uncertain why the last consultation was in October even though follow up had been ordered one month after that visit. During an interview on 7/22/2025 at 11:03 AM, Registered Nurse Unit Manager #18 stated Resident #6 was alert, responsive, and confused. They stated Resident #6 could be combative especially prior to baths/showers. They stated psychiatry had recommended a follow up visit one month after the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/16/2024 consultation, and it was ordered but not completed. They stated the April 2025 psychology consultation was not completed as per order. They stated there was no documented evidence explaining why the consultation/s were not completed. During an interview on 07/22/2025 at 3:43 PM, the Director of Nursing stated Resident #6 last saw psychiatry in 10/2024. They stated there was an order for follow up in one month and they would have expected a November 2024 follow up. They stated the provider had recommended and ordered a psychological consult for Resident #6 in April 2025, but that was not completed either. They stated they could not provide a reason why the consultations were not completed. 2) Resident # 171 had diagnoses including Dementia, Stroke, and Hemiplegia The Annual Minimum Data Set, dated [DATE] documented Resident #171 had severely impaired cognition and required partial to maximal assistance for all activities of daily living. There was no documented evidence in the July 2025 Care Instructions to address Resident #171's position when in the wheelchair. During observation on 07/15/2025 at 1:59 PM, 7/16/2025 at 9:12 AM, 7/16/2025 at 3:14 PM, 7/18/2025 at 12:20 PM Resident #171 was seated upright in a special wheelchair that had the ability to rock back. The wheelchair had leg/footrests. Resident #171's feet did not reach the footrests and were dangling unsupported. The wheelchair did not have a leg board. During an interview on 7/18/2025 at 11:46 AM Certified Nurse Aide #4 stated they now saw how the resident's legs were dangling and were unsupported. They stated at one time the resident had a black thing (leg board) that went behind the legs. They stated they would have to call therapy to have them check the residents chair positioning. During an interview on 7/18/25 at 12:45 PM Licensed Practical Nurse #6 stated they usually placed a pillow to keep the resident's feet from dangling. They stated if there were positioning concerns, they would need to call therapy, so they could evaluate. During an interview on 7/21/2025 10:40 AM Occupational Therapist # 9 stated after their last assessment, the resident was issued a leg board for positioning. They stated the Unit Nurse Care Manager would be responsible for letting the Certified Nurse Aide's know which devices should be in use. They stated if the resident did not use the leg board it could affect how comfortable they were in the chair. During an interview on 7/21/25 at 11:09 AM the Director of Nursing stated it was the Unit Nurse Care Managers responsibility to ensure that Certified Nurse Aides had the information needed to care for residents regarding the use of positioning devices. They stated the Unit Nurse Care Manager should ensure staff had the care instructions documented in care plans and if appropriate the Certified Nurse Aides assignment instructions. 10NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview during the recertification survey conducted 7/15/2025 to 7/22/2025, the facility did not ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers for one of three residents (Residents #171) reviewed for pressure ulcers. Specifically, heel booties were not applied as per physician order and care plan for Resident #171 who was assessed at risk for pressure ulcers. The findings include:The policy & procedure titled Pressure Ulcers Prevention dated 11/2010 documented staff were to identify risk factors for pressure ulcer development and take measures to prevent the formation of pressure ulcers.Resident #171 had diagnoses including Dementia, Stroke, and Hemiplegia.The Quarterly Minimum Data Set (an assessment tool) dated 6/8/25 documented Resident #171 had severely impaired cognition, functional impairment on both sides of the upper and lower body, was dependent with all activities of daily living and was at risk for developing pressure ulcers.The Physician order dated 6/23/25 documented heel boots at all times to bilateral feet.During observation on 07/15/2025 at 1:59 PM, 07/16/2025 at 9:15 AM, and 3:14 PM, and on 7/18/25 at 12:20 PM and 3:00 PM Resident #171 was out of bed in a wheelchair with no offloading boots on their feet. During observation on 7/18/2025 at 8:57 AM and 7/21/25 at 9:00 AM Resident #171 was in bed asleep. Resident #171 did not have heel booties in place.A review of the current Certified Nure Aide Instruction documented the resident should have heel boots at all times.During an interview on 7/18/25 at 11:46 AM Certified Nurse Aide #4 stated they thought the boots were to be worn only when the resident was in bed. After reviewing the Certified Nurse Aide Instructions, they stated the resident should be wearing the heel boots at all times.During an interview on 7/18/25 at 12:45 PM Licensed Practical Nurse #6 stated they had spoken with the unit manager a few days ago and advised them the heel boots were missing. They stated at times when the heel boots went to the laundry they did not come back. They stated if the heel boots were missing, the unit staff should contact the Rehabilitation Department. During an interview on 7/21/25 10:35 AM Physical Therapist #10 stated they were asked to see the resident on Friday related to the resident's missing bilateral heel boots. They stated the resident needed to have their heel boots because they were dependent and were at risk for skin breakdown. During an interview on 7/21/25 at 11:09 AM the Director of Nursing, stated it was the Nurse Care Managers responsibility to ensure Certified Nurse Aides had the information needed to care for the resident They stated that information should include positioning and the use of off-loading devices. During an interview on 07/22/2025 at 11:38 AM the Nurse Practitioner (wound care nurse) stated heel booties were ordered by the physician for pressure relief of the heels. They stated the medical provider had given orders for the heel boots to be worn at all times. They stated the resident should have the heel boots on at all times, except when receiving care, during showers or if the resident was not tolerating them.10NYCRR 415.12(c)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification Survey from 07/15/2025 to 07/22/2025, 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 4 residents (Resident #10) reviewed for Position/Mobility. Specifically, Resident #10 with functional limitation in range of motion was observed on multiple occasions without the use of a left-hand splint as per Occupational Therapy recommendation. The findings included:The policy and procedure titled Care Planning, Orthotic Device, Splints Skin Integrity Monitoring dated last revised 10/10 documented the orthotist/designee will evaluate appropriateness and proper fit of the brace and splint. They will work in collaboration with the referring physician, unit manager and the therapist are to assess the effectiveness and fit of the brace or splint.Resident #10 had diagnoses including Cerebral Infarction and Dementia.The Quarterly Minimum Data Set, dated [DATE] documented Resident #10 had severely impaired cognition, was dependent with all activities of daily living and had functional limitation in range of motion on both sides of the upper and lower extremities.An Occupational Therapy progress note dated 6/21/2025 documented that the long-term goal for the resident is to increase the range of motion to the left wrist and hand by 20 degrees to enable a splinting/positioning device to promote functional positioning. Occupational Therapy recommends the Left-Hand Splint to be worn at all times but removed for cares and range of motion. Occupational Therapy staff provided an in-service education to the unit nursing staff for bilateral hand range of motion stretches as well as hand splints.There was no documented evidence in the electronic medical record of a care plan and physician orders to address contracture management and the use of a left-hand splint.During observations on 07/16/2025 at 10:10 AM, and 07/18/2025 at 10:31 AM Resident #10 was noted with a contracted left hand and did not have a left-hand positioning device in place. During an interview on 07/21/2025 at 10:23 AM, Certified Nurse Aide #25 stated Resident #10 had contractures of their hands. Certified Nurse Aide #25 stated nursing staff received an in-service on the hand braces about a month ago.During an interview on 07/21/2025 at 11:24 AM, Registered Nurse Unit Manager #26 stated there was no order for left-hand splints, no care plan for contractures and no certified nurse aide accountability for the resident to wear the splint every day as per Occupational Therapy recommendation.During an interview on 07/21/2025 at 4:45 PM, the Medical Director stated the procedure was for Physical and Occupational Therapy to make recommendations. They stated the nurse supervisor was responsible for entering orders into the electronic health record and the medical director or one of the nurse practitioners were to sign off on orders.During an interview on 07/22/2025 at 09:59 AM, the Director of Nursing stated recommendations from Physical and Occupational Therapy or other disciplines were supposed go to the unit manager or nurse supervisor to be implemented. They stated orders would be entered by nursing into the electronic health record and Certified Nurse Aide accountability. They stated an order would be implemented while waiting for a medical provider signoff. They stated managers or supervisors were responsible for entering care plans and orders. They stated for Resident #10 the Licensed Practical Nurse or Registered Nurse would be responsible for applying/removing hand splints and braces since they were more complex for proper placement. 10 NYCRR 415.12

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview during the Recertification Survey conducted from 07/15/2025- 07/22/2025, the facility did not ensure that residents were free of medication error rates less than 5% for 1 of 4 residents (Resident #114) reviewed for Medication Administration. Specifically, Licensed Practical Nurse #11 crushed 3 medications and administered them all at once via gastrostomy tube, then combined 3 liquid medications and administered them all at once to for Resident #114 via gastrostomy tube.The findings included:The policy titled Medication Treatment Administration, which was last reviewed on 10/17, documented medications are to be crushed and administered separately, whether administered via oral or gastrostomy route.Resident #114 had diagnoses including Major Depressive Disorder, Epilepsy (seizure disorder), and Gastrostomy status.The care Plan titled Tube Feed last updated on 09/28/19, documented administer medication as ordered.The physician orders dated 7/7/2025 documented Famotidine 20mg tablet give one tablet by gastrostomy tube daily. Lamotrigine 100mg tablet give one tablet by gastrostomy tube daily. Hydrocortisone 5mg tablet give one tablet by gastrostomy tube daily. Potassium chloride 20meq/15ml oral liquid give 22 milliliters by gastrostomy tube once daily. Lactulose 10gram/15ml oral solution give 30 milliliters by gastrostomy tube twice a day. Keppra 100mg/ml oral solution give 10 milliliters by gastrostomy every 12 hours.During the medication administration task on 7/18/2025 at 9:11 AM Licensed Practical Nurse #11 crushed a Hydrocortisone 5-milligram tablet, Lamotrigine 100-mg tablet, and Famotidine 20-mg tablet, and combined the crushed tablets in a cup with water. Licensed Practical Nurse #11 then poured Keppra 100mg/Milliliter (10 milliliter), Potassium chloride 20 meq. (22 milliliter), and Lactulose 10 g (22 milliliters) into a medication cup. Crushed tablets were administered first, followed by a water flush through the gastrotomy tube. All Liquid medications were then administered, followed by a flush.During an interview on 07/22/2025 at 11:21 AM, Licensed Practical Nurse #11 stated they combined all the tablets, administered them and then flushed. They then put all three liquids in a cup, administered them, and then flushed.During an interview on 07/22/2025 at 11:29 AM, the Director of Nursing stated the Nurse should have administered the medication one at a time and flushed after every medication. They stated the Nurse would need to be educated.10 NYCRR 415.12 (m) (2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview conducted during the recertification survey from 7/15/25 to 722/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of infection for 1 of 4 residents reviewed for nutrition. Specifically, Licensed Practical Nurse #12 was observed without the use of a gown when they administered medications via gastrostomy tube to Resident #14 who was on enhanced barrier precautions.The findings included:The policy titled Infection Control Practices Precaution Guidelines, revised 11/2023, documented residents suspected or known to have an infection, and/or transmissible disease will be clinically managed to prevent and control outbreaks and cross contamination. Enhanced barrier precautions guidelines include the use of a gown for high contact resident care Resident #14's diagnoses included dysphagia, and encounter for attention to gastrostomy. A significant change Minimum Data Set (assessment tool) dated 6/20/25 documented Resident #14 had severe cognitive impairment.During an observation and interview on 07/16/2025 at 9:30 AM, Licensed Practical Nurse #12 administered medications via gastrostomy tube to Resident #14 without wearing a gown. Licensed Practical Nurse #12 stated they were aware they did not wear a gown or follow personal protective guidelines when they administered medications to a resident on enhanced barrier precautions. They stated they forgot. During an interview on 07/21/2025 10:39 AM, the Director of Nursing stated during any close interaction, including medication administration, with a resident on enhanced barrier precautions, staff were expected to wear a gown. They stated staff should be supervised by Nurse Unit Managers to ensure proper personal protective equipment policies were followed. They stated infection control guidelines were reviewed during annual mandatory in-services. During an interview on 07/21/2025 at 11:17 AM, Unit Manager Registered Nurse #5 stated the expectation was that all staff wear personal protective equipment while cares were provided for residents on enhanced barrier or other precautions. They stated Licensed Practical Nurse #12 should have worn a gown when they administered medications through a gastrostomy tube for Resident #14. They stated they were responsible for supervising staff and in-servicing staff if concerns were identified. 10 NYCRR415.19