PRINTED: 02/28/2025 FORM ADDROVED

PEFAKTMENT OF HEALTH AND HUN	IAN SERVICES			FORM AFFROVED			
CENTERS FOR MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING 00	COMPLETED			
	155496	B. WI	NG	01/29/2025			
			·				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF FROVIDER OR SUPPLIER			333 W MISHAWAKA RD				

VALLEY	VIEW HEALTHCARE CENTER	ELKHART, IN 46517					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 0000							
Bldg. 00							
	This visit was for the Investigation of Complaint IN00451234. Complaint IN00451234- Federal/state deficiencies related to the allegations are cited at F600, F 609,	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the				
	F610, and F689. Survey dates: January 28 and 29, 2025.		truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared				
	Facility number: 000523 Provider number: 155 AIM number: 100		and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk				
	Census Bed Type: SNF/NF: 79 Total: 79		review for this plan of correction				
	Census Payor Type: Medicare: 2 Medicaid: 75 Other: 2 Total: 79						
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.						
	Quality review completed February 3, 2025						
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect						
	Based on observation, interview, and record review the facility failed to ensure freedom from verbal abuse for 2 of 8 residents reviewed (Resident F and Resident G).	F 0600	Resident F has been followed by Social Services with no psychosocial harm noted. LPN 5 was suspended and has not returned to work.	02/21/2025			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Olivia Shirley

TITLE

(X6) DATE

02/20/2025

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Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo

Executive Director

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 59NV11 Facility ID: 000523 If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/29/2025 155496 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 333 W MISHAWAKA RD VALLEY VIEW HEALTHCARE CENTER ELKHART, IN 46517 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2. All interviewable residents were Findings include: interviewed with no findings related to any allegations of abuse. 1) A complaint filed with the Indiana Department Dependent residents have had of Health, dated 1/13/25 indicated Resident G filed head to toe skin evaluations a grievance alleging Licensed Practical Nurse completed with no findings There (LPN) 5 had been rude and used foul language to were no further findings of abuse Resident F during a medication pass. The report from the interviews and head to indicated Resident F asked LPN 5 to bring her toe assessments. some water to take her medication when the nurse 3. The administrator and DON entered the room with her pills. LPN 5 grabbed were provided 1:1 education on the pills from her bedside table and indicated facility policy & procedure related Resident F should let her know when she wanted to abuse to include: definitions, to take her pills. She indicated Resident F could reporting and investigating not have a breathing treatment because her heart allegations of abuse Education on rate was too high. Resident F told LPN 5 her heart abuse was completed with all rate might not be so high if LPN 5 was not being a staff. With emphasis on INDIANA b****. The complainant indicated LPN 5 closed Abuse & Neglect & the door, and then reopened it, put her head in the Misappropriation of Property: In doorway, called Resident F a b**** and closed the event an allegation is made, the door. The complainant indicated the the facility will take measures to Administrator rewrote the grievance, changing protect residents from harm during what had been originally stated. an investigation ="" span=""> Resident F's record was reviewed on 1/29/25 at ="" span=""> 1:20 PM. Diagnoses included chronic obstructive ="" span=""> pulmonary disease, and chronic respiratory failure 4. The RDO/RDCO will review any with hypoxia. Resident F's current Minimum Data allegation of abuse to validate any Set (MDS) indicated Resident F's Basic interview employees involved are removed for Mental Status (BIMS) score was 15 from the facility pending (cognitively intact). investigation and that allegations are reported within Indiana state In an interview, on 1/29/25 at 1:27 PM, Resident F regulations. This will be an indicated a few weeks ago, she had requested a ongoing practice of this facility for

breathing treatment from LPN 5. LPN 5 obtained a

heart rate by a pulse oximeter device and informed

Resident F her heart rate was too high to receive a

breathing treatment. Resident F indicated LPN 5

was rude during the interaction and it upset her.

Resident 5 indicated the next day, LPN 5 came to

59NV11

the next 6 months. 5 Residents

will be interviewed daily Monday

then monthly for three months. 5

skin evaluations on dependent

regarding abuse for one month and

through Friday by SS/designee

	FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	r í	JILDING	onstruction 00	(X3) DATE : COMPL 01/29/	ETED
	ROVIDER OR SUPPLIER			333 W N	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated Resident I was at her bedside. the water had been and she wanted sommedicine. LPN 5 in difficult with her be water. The resident medicine cup away come back when she medicine and did not water. Resident F in breathing treatment not have it due to he She indicated LPN were rude, causing F indicated she told not be high if the nu Resident F indicated room and closed the LPN 5 opened the dindicated Resident I indicated she did not after the occurrence nurse last night for indicated LPN 5 pointed to take her medicine painful due to LPN indicated LPN 5 was the encounter. She if by LPN 5 and was a her medicine when	did not bring fresh water and F should use the water that Resident F indicated to LPN 5 sitting since the day before the fresh water to take her dicated Resident F was being cause she asked for fresh indicated LPN 5 took her from her, indicated she would the was ready to take her to provide her with any fresh adicated she requested a sand LPN 5 told her she could the rheart rate being too high. S's tone and body language ther to become angry. Resident LPN 5 her heart rate would the weren't being a b****. If LPN 5 stormed out of the stoom. A few seconds later toor, peeked her head in and F was a b****. Resident F to see LPN 5 for a long time. She indicated LPN 5 was her the first time in a while. She ked her hard with her finger in awaken her when it was time to she indicated the poking was 5's long fingernails. She is rude and standoffish during indicated she felt intimidated affaid she would not receive LPN 5 was working. If 12/30/24 at 7:59 AM vices visited Resident F and chosocial distress. If 1/1/25 at 8:01 AM indicated the Resident F and assessed			residents will be completed by DON/designee 5 times daily Monday through Friday for one month and then monthly for the months. Results will be forward to the QAPI committee for any further recommendations and/resolution ="" p=""> ="" p=""> ="" p="""> ="" p=""">	e ree ded	

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155496	B. W	ING		01/29/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			MISHAWAKA RD		
VALLEY	VIEW HEALTHCAR	RE CENTER			RT, IN 46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for psychosocial dis	stress.					
	_	d 1/2/25 at 11:24 AM indicated					
		ted Resident F and assessed					
	for psychosocial dis	stress.					
	During a confidenti	ial interview on 1/28/25 at 6:28					
	-	dicated they were aware of an					
		e 5 calling Resident F a b****.					
	They indicated Resident F reported LPN 5 to						
		staff were not interviewed or					
	aware of any interv	iews being done to investigate					
	the matter. Employ	ee 2 indicated calling a resident					
	a b**** was a form	n of verbal abuse.					
	-	ial interview on 1/29/25 at 1:05					
		dicated Resident F came to					
		ago and asked to file a					
	-	t F told them a nurse passing					
		ude after Resident F had asked					
	_	oills and a breathing treatment.					
		was denied the breathing ner heart rate was too high.					
		d the nurse it might not be so					
		being a b****. Employee 6					
	_	ft the room closing the door,					
		loor, told Resident F she was a					
	*	he door again. Employee 6					
		ented the grievance to the					
		ediately. Employee 6 indicated					
		assigned to interview					
	residents in the area	· ·					
		s when such allegations were					
		indicated they were not					
		additional interviews in this					
		ated calling a resident a b****					
		verbal abuse. She indicated					
	•	sment visits are generally					
		days or more if indicated after					
	an occurrence of ab	ouse.					
			1				Ī

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f '		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00	COMPL	
		155496	B. WIN	G		01/29/	2025
	PROVIDER OR SUPPLIER			333 W N	DDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Employee 7 indicate being filled out with the grievance stated F.	erview on 1/29/25 at 1:24 PM, ed they witnessed a grievance in Resident F. They indicated I LPN 5 had cursed at Resident					
	2) During an interview on 1/29/24 at 1:31 PM, Resident G indicated she had witnessed LPN 5						
		ent F on a few occasions. She					
		ed an occasion where Resident					
		argument over medicine. She					
		Resident F call LPN 5 a					
		returned to the room and b****. She indicated residents					
		ccasion, but staff should not					
		ents like that. She indicated					
	the incident made h						
	indicated Resident (heart failure and hy	nducted on 1/29/25 at 1:22 PM G had diagnoses including pertension. Resident G's tted her BIMS score was 15					
	A document titled (Concern Form, dated 1/2/25,					
		cial Services Director on					
		indicated Resident F reported					
		her and she, the resident,					
		The response section of the					
		Administrator spoke at length					
		rding the incident. The form was counseled on her attitude					
		residents and peers. The form					
		denied cursing and no one					
		e nurse curse. The form was					
	signed by the Admi	nistrator and dated 12/31/25.					
		4/00/07 × 4.0 < D3 = -					
		1/29/25 at 1:36 PM, the ated she had interviewed					

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/29/2025	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD		
VALLEY	VIEW HEALTHCAR	RE CENTER			RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	resident indicated L used a rude tone with nurse had called her indicated she notified followed corporate and department of health interaction as possible did not conduct an item or other residents about indicated she had in nurse denied using and Administrator indicastatements or intervet employees available did not provide an equestion the nurse at the allegation, or the concern form occurred concern. A current policy title Misappropriation Provide and the Administrator of use of foul language constituted verbal allegations.	ated she had no further iews of residents or e for review. The Administrator explanation of the need to bout cursing if it was not in e signature date on the ring before the date of the ed Abuse and Neglect and roperty, undated, provided by n 1/28/25 at 1:58 PM indicated e directed at a resident					
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(Reporting of Alleg						
	review the facility fa of verbal abuse was	on, interview, and record ailed to ensure an occurrence reported to the Department of sidents reviewed (Resident F).	F 06	509	1. Resident F has been followed by Social Services with no psychosocial harm noted. LPN was suspended and has not returned to work.		02/21/2025

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	· /	ЛLDING	00	COMPL	
		155496	B. W	ING		01/29/	/2025
				CTREET	ADDRESS CITY STATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD		
\/ ∆ ⊏ ∨	VIEW HEALTHCAF	RE CENTER			RT, IN 46517		
	VILVVIILALIIIOAF	AL OLIVILIA	,	LLINIA	1 TOO 11		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					2. All interviewable residents		
	Findings include:				interviewed with no findings re	elated	
	1				to any allegations of abuse.		
	_	with the Indiana Department of			Dependent residents have ha	d	
		25, indicated Resident G filed a			head to toe skin evaluations		
		Licensed Practical Nurse (LPN)			completed with no findings Th		
		d used foul language to			were no further findings of ab		
	Resident F during a medication pass. The report indicated Resident F asked LPN 5 to bring her				from the interviews and head	to	
	some water to take her medication when she				toe assessments.		
	entered the room with her pills. LPN 5 grabbed the				="" span="">="" span="">=""		
		-			span="">="" span=""> 3. The administrator and DON		
	pills from the resident's bedside table and indicated Resident F should let her know when						
	she wanted to take her pills. The nurse indicated				were provided 1:1 education of		
	Resident F could not have a breathing treatment				facility policy & procedure related to abuse to include: definition:		
		ate was too high. Resident F			reporting and investigating	5,	
		rt rate might not be so high if			allegations of abuse Educatio	n on	
		ng a b****. The complainant			abuse was completed with all		
		osed the door, then reopened it,			staff. With emphasis on INDIA		
		doorway, called Resident F a			Abuse & Neglect &	711/7	
	_	ne door. The complainant			Misappropriation of Property:	In	
		nistrator rewrote the grievance,			the event an allegation is mad		
		been originally stated.			the facility will take measures		
	changing what had	occir originariy satioa.			protect residents from harm d		
	Resident F's record	was reviewed on 1/29/25 at			an investigation	unig	
		es included chronic obstructive			4. The RDO/RDCO will review	v anv	
		and chronic respiratory failure			allegation of abuse to validate	•	
		dent F's current Minimum Data			employees involved are remo	-	
		d Resident F's Basic interview			from the facility pending		
		BIMS) score was 15			investigation and that allegation	ons	
	(cognitively intact).				are reported within Indiana sta		
					regulations. This will be an		
	Survey report system	m documents submitted by			ongoing practice of this facility	y for	
		ember 2024 and January 2025,			the next 6 months. 5 Residen		
	provided by the Ad	ministrator on 1/28/25 at 1:40			will be interviewed daily Mond		
	PM, did not include	e a report of an allegation of			through Friday by SS/designe	-	
	verbal abuse agains	t Resident F had been			regarding abuse for one mont		
	reported.				then monthly for three months		
					skin evaluations on depender		
	During a confidenti	al interview, on 1/28/25 at 6:28			residents will be completed by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155496	B. WING		01/29/2025
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEI	R		MISHAWAKA RD	
VALLEY	VIEW HEALTHCAI	RE CENTER		RT, IN 46517	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
		dicated they were aware of an		DON/designee 5 times daily	
		e 5 calling Resident F a b****.		Monday through Friday for one	
	1 -	ident F reported LPN 5 to		month and then monthly for th	ree
		loyee 2 indicated they were not		months. Results will be forwar	
		re of any interviews being done		to the QAPI committee for any	<i>'</i>
		natter. They indicated calling a		further recommendations and/	'or
	resident a b**** is	a form of verbal abuse.		resolution	
				="" p="">="" span="">=""	
	During a confident	ial interview, on 1/29/25 at 1:05		p="">="" span="">="" p="">=""	1
		dicated Resident F came to		span="">="" span="">=""	
	them and asked to file a grievance. They indicated Resident F told them a nurse passing her meds			span="">="" span="">=""	
				span="">="" p="">=""	
	became rude after Resident F had asked for water			span="">="" span="">	
	with her pills and a	breathing treatment. She		="" p 4.="" rdo="" rdco=""	
	indicated Resident	F said she was denied the		review="" any="" validate=""	
	breathing treatment	t because her heart rate was		employees="" involved="" are:	=""
	too high. Resident	F then told the nurse it might		removed="" pending=""	
	not be so high if sh	e was not being a b****. She		investigation="" that=""	
	indicated LPN 5 let	ft the room closing the door,		reported="" within="" state=""	
	then reopened the c	loor, told Resident F she was a		regulations.="" this="" be=""	
	b**** and closed the	he door again. Employee 6		ongoing="" practice="" for=""	
	indicated they prese	ented the grievance to the		next="" 6="" months.="" 5=""	
	Administrator imm	ediately. Employee 6 indicated		interviewed="" daily="" monda	ıy=""
	they normally were	e assigned to interview		through="" friday="" by="" ss=	
	residents in the area	a and check for any		designee="" regarding="" one:	
		s when such allegations were		month="" then="" monthly=""	
		ed they were not assigned to		three="" skin="" evaluations="	"
		nterviews in this instance.		dependent="" times=""	
	I	ing a resident a b**** was an		months. results="" forwarded=	:""
	example of verbal a	-		qapi="" committee="" further=	
				recommendations="" or=""	
	In a confidential in	terview, on 1/29/25 at 1:24 PM,		resolution<="" p="">	
		ted they witnessed a grievance		="" p="">	
		h Resident F. She indicated the			
	_	PN 5 had cursed at Resident F.			
		1/29/25 at 1:27 PM, Resident F			
		equested a breathing treatment			
		5 obtained a heart rate by a			
	pulse oximeter dev	ice and informed Resident F her			

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155496	B. W	ING		01/29/	2025
				CTREET	DDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
\/ALLE\/	\/IE\A/ LIE A I TLIC A E	DE CENTED					
VALLET	VIEW HEALTHCAF	RE CENTER		ELNHAI	RT, IN 46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	heart rate was too h	igh to receive a breathing					
	treatment. Resident	F indicated LPN 5 was rude					
	during the interaction	on and it upset her. Resident 5					
indicated the next day, LPN 5 came to give her							
	medicine, did not bi	ring fresh water and indicated					
	the should use the w	vater that was at Resident F's					
	bedside. Resident F	indicated to LPN 5 the water					
	had been sitting sind	ce the day before and she					
	wanted some fresh	water to take her medicine.					
	LPN 5 indicated Re	sident F was being difficult					
	with her because sh	e asked for fresh water. The					
	resident indicated L	PN 5 took her medicine cup					
	away from her and	indicated she would come back					
	when she was ready	to take her medicine and did					
	not provide her with	n any fresh water. Resident F					
	indicated she reques	sted a breathing treatment and					
	LPN 5 told her she	could not have it due to her					
	heart rate being too	high. She indicated LPN 5's					
	tone and body langu	age were rude, causing her to					
	become angry. Resi	dent F indicated she told LPN					
	5 her heart rate wou	lld not be high if she weren't					
	being a b****. Resi	dent F indicated LPN 5					
	stormed out of the r	oom and closed the door. A					
	few seconds later, L	PN 5 opened the door, peeked					
	her head in and indi	cated Resident F was a b****.					
	Resident F indicated	d she did not see LPN 5 for a					
	long time after the o	occurrence. She indicated LPN					
	5 was her nurse last	night for the first time in a					
	while. She indicated	LPN 5 poked her hard with					
	her finger in the left	shoulder to awaken her when					
	it was time to take h	ner medicine. She indicated the					
	poking was painful	due to LPN 5's long					
	fingernails. She ind	icated LPN 5 was rude and					
	standoffish during t	he encounter. She indicated					
	she felt intimidated	by LPN 5 and was afraid she					
	would not receive h	er medicine when LPN 5 was					
	working.						
	A document titled C	Concern Form, dated 1/2/25,					
	provided by the Soc	rial Services Director on					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155496	B. W	ING		01/29	/2025
				STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	3			MISHAWAKA RD		
VALLEY	VIEW HEALTHCA	RE CENTER			RT, IN 46517		
	<u> </u>				· 		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
IAU		indicated Resident F reported a		IAU			DATE
		er and she, the resident cursed					
		esponse section of the form					
		nistrator spoke at length with					
		the incident. The form					
		was counseled on her attitude					
		residents and peers. The form					
	indicated the nurse denied cursing and no one						
	reported hearing the nurse curse. The form was						
	signed by the Administrator and dated 12/31/24.						
	Signed by the ridin	mismator una autoa 12/31/27.					
	In an interview on	1/29/25 at 1:36 PM, the					
	Administrator indicated she had interviewed						
	Resident F about her interaction with LPN 5, she						
	indicated LPN 5 ha	d seemed annoyed and used a					
	rude tone with her,	but did not mention the nurse					
	had called her a b*	***. She indicated she notified					
	her supervisors and	followed corporate guidance.					
	She indicated she d	id not report the abuse					
	allegation to the de	partment of health because she					
	did not view the int	teraction as possible abuse.					
	She indicated she d	id not conduct an					
	investigation or inte	erview staff or other residents					
	about the allegation	s. She indicated she had					
		, and she denied using foul					
	" "	ninistrator indicated she had no					
		or interviews of residents or					
		e for review. The Administrator					
	•	explanation of the need to					
	_	about cursing if it was not in					
	the allegation or the	e signature date occurring					
		he concern. The Administrator					
	_	eiving an allegation of abuse,					
		d be suspended, the					
		lth should be notified, and the					
	Administrator shou	ld begin an investigation.					
		led Abuse, Neglect and					
		f Property, undated, provided or on 1/28/25 at 1:58 PM					
	I by the Administrate	or on 1/28/23 at 1:38 PM	1				I

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155496	B. W	ING		01/29/	/2025
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			MISHAWAKA RD		
\/ALLEV	VIEW HEALTHCAF	DE CENTER			RT, IN 46517		
VALLET	VIEW HEALTHCAP	NE GENTER		ELKITA	IN 1, IN 40317		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated use of fou	l language directed at a					
	resident constituted	verbal abuse. The policy					
	indicated required n	notification of agencies, the					
	physician and reside	ent representative should be					
	completed in a time	ely manner.					
	This citation is relat	ted to complaint IN00451234.					
	3.1-28(c)						
F 0610	483.12(c)(2)-(4)						
SS=D	Investigate/Prever	nt/Correct Alleged Violation					
Bldg. 00							
			F 00	610	1. Resident F has been follow	ed	02/21/2025
		on, interview, and record			by Social Services with no		
		ailed to ensure an allegation of			psychosocial harm noted. LPN	1 5	
		vestigated for 2 of 8 residents			was suspended and has not		
	reviewed (Resident	F, Resident G).			returned to work.		
					2. All interviewable residents v	vere	
	Findings include:				interviewed with no findings re	lated	
					to any allegations of abuse.		
		d with the Indiana Department			Dependent residents have had	t	
		Resident G filed a grievance			head to toe skin evaluations		
	alleging Licensed P	ractical Nurse (LPN) 5 had			completed with no findings All		
		foul language to Resident F			residents that could be intervie	ewed	
		n pass. Resident F asked LPN 5			had an interview competed an	ıd all	
		vater to take her medication			non-interviewable residents ha	ad a	
	when she entered th	ne room with her pills. LPN 5			head to toe assessment		
	grabbed the pills fro	om her bedside table and			completed. There were no furt	her	
		F should let her know when			findings of abuse from the		
		her pills. She indicated			interviews and head to toe		
		ot have a breathing treatment			assessments.		
		ate was too high. Resident F			3. The administrator and DON	ļ	
		rt rate might not be so high if			were provided 1:1 education of	n	
		ng a b****. The complainant			facility policy & procedure rela		
		osed the door, then reopened it,			to abuse to include: definitions	3,	
	*	doorway, called Resident F a			reporting and investigating		
	b**** and closed th	ne door. The complainant			allegations of abuse Education	n on	
	indicated the Admir	nistrator rewrote the grievance,			abuse was completed with all		
	changing what had	been originally stated.			staff. With emphasis on INDIA	NA	

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	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	ľ	JILDING	onstruction 00	(X3) DATE COMPL 01/29	SURVEY LETED
VALLEY (X4) ID		RE CENTER STATEMENT OF DEFICIENCIE	STREET ADDRESS, CITY, STATE, ZIP COD 333 W MISHAWAKA RD ELKHART, IN 46517 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE				(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	1:20 PM. Diagnose pulmonary disease, with hypoxia. Resset (MDS) indicate for Mental Status (cognitively intact) During a confident PM, Employee 2 in occurrence of Nurse The employee indicate of any intimity investigate the mat resident a b**** is During a confident PM, Employee 6 in them and asked to the Resident F told the became rude after I with her pills and a indicated Resident too high. Resident not be so high if shindicated LPN 5 lethen reopened the comparison of the season of the pulmon of the so high if shindicated LPN 5 lethen reopened the comparison of the pulmon of the season of the pulmon of the	was reviewed on 1/29/25 at a sincluded chronic obstructive and chronic respiratory failure ident F's current Minimum Data and Resident F's Basic interview BIMS) score was 15. ital interview, on 1/28/25 at 6:28 adicated they were aware of an act of a scalling Resident F a b****. Cated Resident F reported LPN and they were not interviewed erviews being done to ter. They indicated calling a a form of verbal abuse. ital interview, on 1/29/25 at 1:05 adicated Resident F came to file a grievance. They indicated m a nurse passing her meds Resident F had asked for water breathing treatment. She F said she was denied the text because her heart rate was F then told the nurse it might the was not being a b****. She fit the room closing the door, told Resident F she was a the door again. Employee 6			Abuse & Neglect & Misappropriation of Property: the event an allegation is mathe facility will take measures protect residents from harm of an investigation ="" span=""> ="" span=""> ="" span=""> ="" span=""> 4. The RDO/RDO will review any allegation of a to validate any employees invare removed from the facility pending investigation and the allegations are reported within Indiana state regulations. This be an ongoing practice of this facility for the next 6 months. Residents will be interviewed Monday through Friday by SS/designee regarding abuse one month and then monthly three months. 5 skin evaluation dependent residents will be completed by DON/designee times daily Monday through for one month and then month for three months. Results will forwarded to the QAPI committed for any further recommendation and/or resolution	de, to during CO buse volved at n s will s for for ons e 5 -riday hly be ittee	

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example of verbal abuse.

indicated they presented the grievance to the Administrator immediately. Employee 6 indicated they normally were assigned to interview residents in the area and check for any

psychosocial effects when such allegations were made. They indicated they were not assigned to do any additional interviews in this instance. They indicated calling a resident a b**** was an

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	l í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 01/29 /	ETED	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 333 W MISHAWAKA RD ELKHART, IN 46517					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	In a confidential int Employee 7 indicate being filled out with grievance stated LP. In an interview, on indicated she had refrom LPN 5. LPN: pulse oximeter devi heart rate was too h treatment. Resident during the interactic indicated the next d medicine and did not indicated she should Resident F's bedside 5 the water had been and she wanted som medicine. LPN 5 in difficult with her bewater. She indicated away from her, indicated she request LPN 5 told her she heart rate being too tone and body language become angry. Resist 5 her heart rate wou being a b****. Resiststormed out of the refew seconds later L her head in and indicated for indicated the request stormed out of the refew seconds later L her head in and indicated the redicated the redica	erview, on 1/29/25 at 1:24 PM, ed they witnessed a grievance in Resident F. She indicated the N 5 had cursed at Resident F. 1/29/25 at 1:27 PM, Resident F requested a breathing treatment 5 obtained a heart rate by a ce and informed Resident F her eight to receive a breathing F indicated LPN 5 was rude on and it upset her. Resident 5 ay, LPN 5 came to give her of bring fresh water and diuse the water that was at e. Resident F indicated to LPN in sitting since the day before the fresh water to take her dicated Resident F was being breause she asked for fresh the LPN 5 took her medicine cup cated she would come back to to take her medicine and did in any fresh water. Resident F sted a breathing treatment and could not have it due to her high. She indicated LPN 5's mage were rude, causing her to dent F indicated she told LPN dent F indicated LPN 5 oom and closed the door. A PN 5 opened the door, peeked cated Resident F was a b****. It she did not see LPN 5 for a		TAG	DEPICIENCY)		DATE	
	5 was her nurse last while. She indicated	night for the first time in a large LPN spoked her hard with shoulder to awaken her when						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/29/2025				
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 333 W MISHAWAKA RD ELKHART, IN 46517					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A CITION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	poking was painful fingernails. She ind standoffish during t she felt intimidated would not receive h working.	ner medicine. She indicated the due to LPN 5's long icated LPN 5 was rude and the encounter She indicated by LPN 5 and was afraid she ter medicine when LPN 5 was						
	Resident G indicate being rude to Resid indicated she recall F and LPN 5 had ar indicated she heard b****, and LPN 5 resident F was a b' used that word on comments.	iew, on 1/29/24 at 1:31 PM, and she had witnessed LPN 5 ent F on a few occasions. She ed an occasion where Resident an argument over medicine She Resident F call LPN 5 a returned to the room indicating *****. She indicated residents becasion, but staff should not ents like that. She indicated						
	A record review co- indicated Resident (heart failure and hy	nducted on 1/29/25 at 1:22 PM G had diagnoses including pertension. Resident G's ated her BIMS score was 15						
	provided by the Soc 1/29/25 at 1:16 PM nurse was rude to h The response section Administrator spok regarding the incid nurse was counseled approach with reside indicated the nurse reported hearing the	Concern Form, dated 1/2/25, cial Services Director on indicated Resident F reported a er and she cursed at the nurse. On of the form indicated the e at length with the nurse ent. The form indicated the d on her attitude and lents and peers. The form denied cursing and no one e nurse curse. The form was inistrator and dated 12/31/24.						
	In an interview, on	1/29/25 at 1:36 PM, the						

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE S' COMPLE 01/29/2	ETED
	ROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0689	Resident F. about he indicated LPN 5 had rude tone with her, had called her a b** her supervisors and She indicated she di allegation to the dep did not view the interestigation or interviewed LPN 5 language. The Adm further statements of employees available did not provide an equestion the nurse at the allegation or the before the date of the A current policy titl Misappropriation of by the Administrator indicated use of four resident constituted indicated each occur investigated timely. Administrator was reinvestigation.	rview staff or other residents s. She indicated she had and she denied using foul inistrator indicated she had no r interviews of residents or e for review The Administrator explanation of the need to bout cursing if it was not in signature date occurring				
SS=D Bldg. 00	Free of Accident Hazards/Supervisi	on, interview, and record	F 0689	Resident D has had a new smoking evaluation complete		02/21/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2025	
1 111111				ADDRESS, CITY, STATE, ZIP COD	0 1/120/12020	
NAME OF PROVIDER OR SUPPLIER				MISHAWAKA RD		
VALLEY	VIEW HEALTHCAF	RE CENTER	ELKHA	RT, IN 46517		
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ailed to ensure assessment,		care plan updated to reflect		
		planning were accurately		current status		
	recorded pertaining to smoking for 1 of 4 residents			2. The executive director was		
	reviewed (Resident D).			provided 1:1 education on facility		
				policy and procedure related to)	
	Findings include:			documentation by the Regiona		
				Director of Clinical Operations		
	-	dum filed with the Department		3. An audit has been complete	ed	
		6/25, indicated some residents		for all residents who wish to		
		n their rooms the previous		smoke, to include a new smok	ing	
	night. The complain			evaluation, care plan and revie	ew of	
		old the nursing staff on duty		facility smoking Policy.		
	not to document the indoor smoking in the			Social Services and nursing		
	residents' charts. The complainant also alleged the			staff have been educated on		
	Administrator instructed the department heads			facility policy & procedure related		
	and corporate staff present in the morning			to smoking policy and updating	g	
	meeting the following day not to chart anything			care plans. Identified behavior	s	
	about the indoor smoking.			and/or change of condition are	:	
				discussed in daily stand up an	d	
	During an observati	ion, on 1/29/24 at 1:45 PM,		care plans and smoking		
	Resident D was obs	served in the smoking area with		evaluations will up updated as		
	a lit cigarette smoki	ing An unidentified staff		necessary. Guardian		
	member was superv	vising several residents in the		Angels/designee will provide v	isual	
	smoking area at the	time.		checks daily Monday through		
				Friday for one month and then		
	During an interview	on 1/29/25 at 1:46 PM,		monthly for six months to ensu	ire	
		d he smoked at the designated		smoking items are properly sto	ored	
	-	the door with a staff member		and there is no evidence of		
	_	d some residents smoked		smoking inside the		
		some needed to be supervised.		facility. Identified behaviors an	d/or	
		not know why he had to be		change of condition are discus	sed	
	supervised.			in daily stand up and care plar	ns	
				and smoking evaluations will u		
	Resident D's record was reviewed on 1/29/24 at			updated as necessary. Guardian		
	_	ses included chronic		Angels/designee will provide visual		
	_	ary disease and shortness of	checks daily Monday through			
	breath.			Friday for one month and then		
				monthly for six months to ensu	ıre	
		t quarterly Minimum Data Set		smoking items are properly sto	ored	
	(MDS) indicated th	eir Basic Interview for Mental		and there is no evidence of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/29/2025 155496 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 333 W MISHAWAKA RD VALLEY VIEW HEALTHCARE CENTER ELKHART, IN 46517 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Status (BIMS) score was 15 (cognitively intact). smoking inside the facility. 5 Administrator/designee will Resident D's current care plan titled ...uses meet with residents on adverse nicotine products ...Resident is a supervised weather days to discuss smoking smoker ...indicated the resident had a problem of plans and ability for next smoking using cigarettes, with a goal date of 4/22/25. time. A thermometer was provided Interventions included educating the resident to for residents to view the use the smoking area to smoke, and the resident is temperature outside as a visual an independent smoker. reminder. Identified behaviors and/or change of condition are A smoking assessment dated 1/15/24 indicated discussed in daily stand up and Resident D used cigarettes and was independent care plans and smoking with smoking. evaluations will up updated as necessary. Guardian A smoking assessment dated 1/21/25 indicated Angels/designee will provide visual Resident D used cigarettes and required checks daily Monday through supervision to smoke cigarettes. No changes in Friday for one month and then diagnoses, cognition, vision, dexterity, frequency monthly for six months to ensure or safety were indicated on the form to validate smoking items are properly stored the change in status. No progress notes between and there is no evidence of 1/15/24 and 1/21/24 pertaining to smoking were smoking inside the facility. The available for review. results of these audits/observations will be In an interview, on 1/28/25 at 10:12 AM, the reported, reviewed and trended for Director of Nursing indicated Resident D, and compliance and further follow up another resident were caught smoking in their through the facility QAPI rooms on a very cold day because they were Committee. angry about not being able to go outside and smoke. In an interview, on 1/28/25 at 11:13 AM, the Administrator indicated she was aware of a different resident having an occurrence of indoor smoking but was not aware of any others. In a confidential interview, on 1/29/25 at 1:05 PM Employee 6 indicated they were aware of a few residents who reportedly smoked in their rooms on a very cold day when they were not allowed to

go outside due to the low temperatures. Employee

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
		155496	B. WING			01/29/2025	
			STI	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER			33	3 W N	/IISHAWAKA RD		
VALLEY VIEW HEALTHCARE CENTER			EL	KHAF	RT, IN 46517		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
		moking assessment was done					
		t D now required supervision					
	_	oors. They indicated the					
	Administrator anno	unced in the morning meeting					
	that staff were not a	allowed to document the					
	occurrences of indoor smoking. They indicated						
	upon a violation of the smoking policy, staff						
	should stop the resident from smoking in an						
	unsafe area, educate them on the policy and						
	safety standards, remove the smoking materials						
	from their possession, perform a new smoking						
	assessment and update the care plan. All the						
	events should be documented and reported to the						
	physician and representative.						
	A current policy titled Resident/Patient smoking						
		ded by the Administrator on					
	_	indicated smoking supervision					
		by the interdisciplinary team					
		The policy indicated staff					
		the reason for the need to					
		care plan and document					
		notification. The policy also					
	-	should only occur in					
	designated areas.	,					
	This citation is relat	ted to complaint IN00451234.					
	3.1-45 (a)(2)						

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