STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	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 IN00377480, IN00378592, IN00378735, IN00378881, IN00378854 and IN00379238. Complaint IN00377480 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00378592 - Substantiated. Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00378735 - Substantiated. Federal/state deficiencies related to the allegations are cited at F770. Complaint IN00378881 - Substantiated. Federal/state deficiencies related to the allegations are cited at F694 and F770. Complaint IN00378854 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00379238 - Substantiated. Federal/state deficiencies related to the allegations are cited at F770. Unrelated deficiencies are cited. Survey dates: April 25, 26, 27, 28, and 29, May 2, 4, and 5, 2022 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type:	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the facility Recertification and State Licensure with a Complaints (IN00377480, IN00378592, IN00378735, IN00378854, IN00378881, IN00379238) on 5/5/2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 10 Medicaid: 70 Other: 2 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/23/22.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on random observation, record review and interview, the facility failed to ensure a Care Plan was current and implemented for a resident who was known to "hoard" hazardous cleaning products in his room such as Clorox clean-up, Pine Sol and other potentially harmful substances for 1 of 11 residents whose care plans were reviewed. (Resident K) Finding includes: On 5/2/22 at 1:30 P.M., an observation was made of Resident K's room. The following was noted: 10 spray bottles of Clorox clean up, 1 bottle of Lysol all purpose cleaner, 2 spray bottles of Simply Green cleaner, 1 spray bottle of Zep 505 degreaser, 4 spray bottles of Clorox Tilex Mold and Mildew cleaner, 7 Pine Sol Lemon Fresh cleaner, 1 spray bottle of Spic and Span, 2 original Pine Sol scented bottles, Lysol cleaning wipes, and Clorox cleaning wipes.	F 0656	F 656 Develop/Implement Comprehensive Care Plans 1) Resident K was not harmed by the alleged deficient practice. Education was provided to the resident regarding the hazardous materials in his room and the need to remove the products. All hazardous chemicals were immediately removed from Resident K's room. Resident K's behavior plan of care was updated to add "hoarder" of cleaning products/hazardous materials. 2) The Director of Nursing (DON) or designee will complete a facility wide audit on or before the date of compliance to identify any residents who are hoarders of any	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 5/2/22 at 2:10 P.M., a clinical review was conducted. Diagnoses included, but were not limited to: paranoid schizophrenia, obsessive-compulsive disorder, unspecified, delusional disorders, and bipolar disorder, unspecified. A Care Plan, dated 10/7/2020, indicated "... [Resident K] has a behavior problem r/t [related to]hoarding, i.e. tissues, and open mouthwash containers, and cups, 2 liter bottles...Interventions/Tasks: Encourage to explain why you need him to clean up his room and give him clear boundaries of what to get rid of...." A Care Plan, dated 4/14/21, indicated "... [Resident K] has delusions, i.e. the air is not pure, there is ash coming up from the ground, the cups of liquid in his room help him purify the air around him...Interventions/Tasks: Encourage to explore other ways of purifying the air instead of using cups with mouthwash in them...Reassure the air in the facility is safe...." On 5/2/22 at 2:30 P.M., during an interview with the Divisional Director of Clinical Operations, she indicated Resident K had a known history of hoarding cleaning supplies, pizza boxes, soda bottles, juice glasses and other items in his room, and care planning had been initiated related to hoarding issues. It did not address the hoarding of potentially harmful cleaning products. On 5/2/22 at 3:00 P.M., during an interview with the Director of Nursing, she indicated the care plan that had been developed to address Resident K's hoarding did not address cleaning products or potentially hazardous substances.		cleaning products/hazardous materials and ensure that any residents identified as potential "hoarder" has an updated behavior plan of care. 3) The Corporate Nurse or designee will educate the IDT on the facility policy for Plan of Care Overview with emphasis on development of person-centered care plan for those residents who have been identified as hoarding hazardous products. 4) The Social Service Director will audit 5 residents care plans x 4 weeks, then 3 residents care plans x 4 weeks, then 5 residents care plan monthly x 4 months to ensure development of a person-centered care plan for those residents who are identified as hoarders of hazardous chemicals are in place, accurate and implemented. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	There were no updates to the Care Plan since 4/14/22 and interventions to address hoarding of potentially hazardous materials had not been implemented. A policy for care planning was requested but not provided at the time of exit. 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure necessary services to maintain good grooming were provided related to nail care for 1 of 6 residents reviewed for Activities of Daily Living and neglect. (Resident C). Finding includes: During an observation on 4/28/22 at 12:45 P.M., Resident C was noted in the dining area in a Broda Chair having lunch. The resident's finger nails were noted to be in need of trimming. On 5/2/22 at 10:00 A.M., Resident C's clinical records were reviewed. Resident C's most recent comprehensive Minimum Data Set (MDS), was a quarterly assessment dated 2/08/2022. The assessment indicated Resident C was severely cognitively impaired, required extensive to total assistance for all areas	F 0677	F 677 ADL Care Provided for Dependent Residents 1) Resident C was not harmed by the alleged deficient practice. Resident C nails were trimmed at the time of findings. 2) All dependent residents who require assistance with nail care have the potential to be affected by the alleged deficient practice. An audit will be conducted on all dependent residents who require assistance with nail care to ensure their ADL needs have been met with an emphasis on nail care. 3) The DON/designee will educate the Nursing staff on the facility policy for Nail and Hair	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of activities of daily living and was totally dependent on staff for personal hygiene and bathing. A Care Plan for self care performance deficit, dated 10/07/20 with a target date of 7/17/22, included an intervention that indicated, "...BATHING: Check nail length and trim and clean on bath day as necessary..." On 5/02/22 at 10:26 A.M., the Director of Nursing provided Resident C's untitled forms, indicating they were the forms the facility used for the documentation of bathing and skin problems. Information found on the forms included, but was not limited to, the following: 4/01/22, "...Charge Nurse was informed that nails need to be cut. Yes..." 4/11/22, "...Charge Nurse was informed that nails need to be cut. Yes..." 4/05/22, "...Charge Nurse was informed that nails need to be cut. Yes..." 4/19/22, "...Charge Nurse was informed that nails need to be cut. Yes..." 4/22/22, "...Charge Nurse was informed that nails need to be cut. Yes..." During an interview on 5/02/22 at 10:30 A.M., the Director of Nursing indicated there was no documentation of nail care for Resident C, and when a Certified Nursing Assistant (CNA), documents nail care is needed, the nursing staff should complete the nail care. On 4/29/22 at 3:00 P.M., the policy entitled, "Nail and Hair Hygiene Services," dated 11/01/13 and revised on 4/14/17, was provided by the Director of Nursing. The policy indicated,"...This facility will provide routine care for the resident for hygienic purposes and for the psychosocial		Hygiene Services with emphasis on providing nail care as appropriate. 4) The DON/designee will monitor ADL Care for dependent residents with emphasis pertaining to nail care. Utilizing the ADL Care Audit-“nail care”, the DON will monitor 5 residents weekly x 8 weeks. Then 5 residents nail care will be monitored monthly x 4 months. This will be an ongoing practice of this facility. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	well-being of the resident...includes nail hygiene services including routine trimming, cleaning and filing..." This Federal tag relates to complaint IN0000378854. 3.1-38(3)(E)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident with a history of hoarding had an environment free of hazards related to an abundance of cleaning supplies not stored safely for 1 of 1 residents reviewed for accidents/ hazards. (Resident K) Finding includes: On 5/2/22 at 1:30 P.M., Room 113 was observed with the following: On the floor of the room inside the privacy curtain on Resident K's side of the room, there was a 24 ounce spray bottle of Clorox disinfectant lying on the bed, a spray bottle of lemon scented Lysol brand 30 ounce disinfectant, and on the overhead	F 0689	F 689 Free of Accident Hazards/Supervision/Devices 1) Resident K was not harmed by the alleged deficient practice. Education was provided to the resident regarding the hazardous materials in his room and the need to remove the products. All hazardous chemicals were immediately removed from Resident K's room. 2) The DON or designee will complete a facility wide audit on or before the date of compliance to identify any residents who have any cleaning products/hazardous materials in their room. Education	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	light there was a 24 ounce spray bottle of Clorox disinfectant. On the bedside table located on the roommate's side of the room, two 40 ounce open bottles of Pine Sol brand multi surface cleaner that were approximaetly 3/4 of the way full, two 32 ounce spray bottles of Clorox brand Tilex Mold and Mildew cleaner, and two full 24 ounce spray bottles of Simple Green cleaner. On the window ledge, there was a open container of Lysol disinfectant wipes, and Clorox disinfectant wipes. A large bottle of mouthwash with a clear blue and yellow colored substance was noted, and Resident K indicated there was only water in the mouthwash bottle. On the floor below the window, there were three open 28 ounce bottles of Pine Sol lemon scented disinfectant that were full. On the floor beside the dresser facing the window, there were 2 half full urinals, a pizza box and another 24 ounce Clorox spray bottle. Behind the dresser was an area approximately 6 inches x 16 inches of a spilled unknown green substance. On top of the wardrobe, there were two open 28 ounce Pine Sol lemon scented bottles of disinfectant and one 32 ounce spray bottle of Spic and Span disinfectant that was approximately half full. In the restroom, there were two 24 ounce spray bottles of Clorox disinfectant on the shelf to the right side of the mirror, two 24 ounce spray bottles of Clorox disinfectant housed in a box stored		will be provided to the resident regarding hazardous materials and storage and items will be removed. 3) The DON will educate the IDT and nursing staff utilizing the facility policy for Hazardous Materials Storage on or before the date of compliance. 4) The DON/Designee will audit via observation 10 residents rooms to ensure there are no hazardous chemicals weekly x 4 weeks, then 5 residents rooms weekly x 4 weeks, then 10 residents room monthly x 4 months. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	underneath the sink and a purple scented toilet bowl apparatus noted underneath the toilet seat. During an interview with Resident K at the time of the observation, he indicated the cleaning supplies were there and kept open to dissolve the smell of smoke that came through his window. During an interview with the Housekeeping Supervisor on 5/2/22 at 1:50 P.M., she indicated the floor was mopped in Room 113 daily and Resident B poured out a substance all over the floor afterwards. During an interview with the Divisional Director of Clinical Operations on 5/2/22 at 2:45 P.M., she indicated the resident had a known history of hoarding cleaning supplies, pizza boxes, soda bottles, juice glasses and other items in his room, and care planning had been initiated related to hoarding issues. It did not address the hoarding of potentially harmful cleaning products. A record review for Resident K was conducted on 5/2/22 at 2:10 P.M. Resident K was admitted on 7/31/2020. Diagnoses included, but were not limited to: paranoid schizophrenia, obsessive-compulsive disorder, unspecified, delusional disorders, and bipolar disorder, unspecified. A Care Plan, dated 10/7/2020, indicated " ... [Resident K] has a behavior problem r/t [related to]hoarding, i.e. tissues, and open mouthwash containers, and cups, 2 liter bottles ...Interventions/Tasks: Encourage to explain why he is hoarding and then try to explain why you need him to clean up his room and give him clear boundaries of what to get rid of ...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Care Plan, dated 4/14/21, indicated " ...[Resident K] has delusions, i.e. the air is not pure, there is ash coming up from the ground, the cups of liquid in his room help him purify the air around him ...Interventions/Tasks: Encourage to explore other ways of purifying the air instead of using cups with mouthwash in them ...Reassure the air in the facility is safe ...." A warning label on the back of the cleaning products indicated "..Hazardous to humans and domesticated animals. Causes substantial but temporary eye pain. Harmful if inhaled. Wear safety glasses...." There was no documentation to indicate the hazardous substances had been identified, monitored or addressed for safety. Two residents resided in the room. A policy, titled " Hazardous Materials Storage" with an effective date of 1/25/2019, was provided by the Director of Nursing at 2:12 P.M. on 5/2/22. She indicated the policy was the one currently being used by the facility. The policy indicated " ...Chemicals and Toxins- Various materials in the resident environment can pose a potential hazard to Residents. Hazardous materials can be found in the form of solids, liquids, gases, mists, dust, fumes and vapors. The routes of exposure for toxic materials may include inhalation, absorption, or ingestion. For a material to pose a safety hazard to a resident, it must be toxic, caustic, or allergenic, accessible and available in a sufficient amount to cause harm (State Operations Manual, 2017) ...a. Hazardous materials include any item (chemical, physical, or radiological) that poses a threat and/or potential harm to humans or the environment. b. Hazardous materials may include but are not limited to: i. Chemicals 1. Cleaning and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disinfecting products (wipes, liquids, sprays) ...." 3.1-25(j)(m)(n)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure orders were provided for the care and maintenance of an intravenous (IV) treatment for 1 of 1 residents reviewed for IV treatment. (Resident E) Finding includes: The clinical record for Resident E was reviewed on 5/4/22 at 2:00 P.M. Diagnoses included, but were not limited to: type 2 diabetes mellitus with diabetic neuropathy, unspecified and chronic kidney disease, stage 3, unspecified. A Progress Note, dated 4/21/22 at 12:52 P.M., indicated "...Lab results received and BUN [Blood Urea and Nitrogen, a test that monitors kidney function] high. Per NP [Nurse Practitioner] resident is dehydrated. NP started IV in her left forearm running normal saline at 80 ml/hr...." A Progress Note, dated 4/21/22 at 1:11 P.M., indicated "16. AKI [Acute Kidney Injury] start ns [normal saline] 0.9% at [sic] 80 ml/hr x 3 liter. A Physician's Progress Note, dated 4/21/22 at 1:11	F 0694	F 694 Parental/IV Fluids 1) Resident E was not harmed by the alleged deficient practice. Intravenous orders are no longer active. 2) All residents with intravenous lines have the potential to be affected by the alleged deficient practice. A facility-wide audit will be conducted on or before the date of compliance to ensure that all residents with an intravenous line have orders to monitor IV. 3) The DON/Designee will educate all licensed nurses on the facility policy for Infusion Therapy Procedure on or before the date of complince. 4) The DON/Designee will audit all residents with an intravenous line to ensure orders for monitoring IV are in place and implemented	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., indicated "...IV reseal started 20 [gram], iv fluid patent, good flush and blood return, no infiltrates...." A Medication Administration Record, dated 4/1/22 - 4/30/22 indicated, "... 04/23/2022 at 0940...Sodium Chloride (PF) Solution 0.9% Use 80 ml/hr [milliliter per hour] intravenously one time a day for dehydration please give 4 liters...." No further orders for monitoring were noted on the Medical Administration Record. During an interview on 5/5/22 at 1:07 P.M. with the Director of Nursing, she indicated Resident E was no longer receiving intravenous fluids, but while she had been, there were no orders written to monitor the IV while the resident was receiving intravenous fluids. A Progress note, dated 4/27/22 at 10:22 A.M., indicated Resident was seen by the NP and orders were written to discontinue the intravenous fluid infusions of Normal Saline. A procedure, titled " Infusion Therapy Procedure" was provided by the Director of Nurses on 5/5/22 at 1:05 P.M., and indicated this was the current procedure being used for infusion therapy orders. The policy indicated "...General Guidance: 1. A physician's order is necessary to give Intravenous fluids and electrolytes. 6. Resident should be monitored frequently when continuous fluids are infusing. Monitor for signs and symptoms of fluid overload, catheter and insertion site complications, and the resident's tolerance of procedure. Fluids may be stopped by a Nurse if signs of a problem are present. 7. When infusing continuous fluids, the tubing should be changed every 96 hours, and as needed if sterility is compromised or per facility policy. Assessment:		on the following schedule: all residents weekly x 8 weeks and then all residents monthly x 4 months. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Inspect intravenous catheter and insertion site for signs and symptoms of complications at scheduled intervals (per facility policy), during routine site car and when changing administration sets. Procedure: 1. Wash hands. Apply gloves. 2. Prime tubing of administration set. 3. Disinfect needleless connection device with alcohol wipe. 4. Flush catheter using normal saline per facility protocol. 5. Connect primed administration set to needleless connection device. 6. Open roller clamp. 7. Establish prescribed rate of flow. 8. When infusion is complete: For Continuous therapy: a. Mark solution container with label that states when bag was started and approximate time of completion. b. Use a time tape on bag to mark time intervals. c. Never write directly on the bag with ink or marker, always use a label or tape. 9. Document procedure in the resident's medical record and on the intake/output record." This Federal tag relates to complaint IN00378881. 3.1-47(a)(2)			
F 0770 SS=E Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to provide timely laboratory services per physician's order to meet the needs of the residents and avoid a delay in treatment and hospitalization for 4 of 5 residents reviewed for	F 0770	F 770 Laboratory Service 1)Resident D, E, M,N are confidential as part of this complaint survey.	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	laboratory services and 1 of 5 residents reviewed for infection control. (Resident D, E, M, N, & G) Findings include: 1. On 5/2/22 at 10:45 A.M., the clinical record for Resident D was reviewed. Resident D was admitted to the facility on 5/27/2020 with diagnoses included, but not limited to: type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, acquired absence of Right leg below knee, acquired absence of Left leg below knee, and chronic obstructive pulmonary disease, unspecified. A Progress Note, dated 4/22/22 at 3:52 P.M., indicated Resident D was seen by the NP (Nurse Practitioner) for complaints of nausea and vomiting. The NP ordered the following: "...Plan: continue zofran [a medication to aide with nausea and vomiting] and urinalysis [a test to determine if a infection in the urinary tract is present] stat [timeframe indicating right now] ..." A Progress Note, dated 4/23/22 at 1:57 P.M., indicated "...Resident with c/o [complaint of] nausea and vomiting off and on for the past week, states [NP] saw her yesterday...stat UA [urinalysis] ordered but lab will not pick up until Monday...now c/o dizziness 125/78 [blood pressure], 122 [heart rate], 18 [respirations], 97.6 [temperature], 94% [oxygen level in blood] at room air, MD notified and new order for STAT CBC [Complete Blood Count] with diff [differential] and CMP [Complete Metabolic Panel], resident is own POA [Power of Attorney] and notified of lab orders...." A Progress Note, dated 4/23/22 at 11:09 P.M., indicated "... Resident c/o n/v [nausea and		2) All residents with an order for labs have the potential to be affected by the deficient practice. The Director of Nursing/Designee will conduct an audit of all residents with an order for a lab test on or prior to the date of compliance to validate all tests were complete, results received and MD was notified. 3) The Director of Nursing/Designee will educate all licensed nursing staff on or before the date of compliance on the facilities policy for Laboratory and Radiological Services and Results reporting with emphasis on timely completion of labs. 4) The Director of Nursing/Designee will complete an audit to verify that all labs have been completed, results received and have been reported to physician, and follow up orders implemented timely. This will be an ongoing process completed in the clinical meeting 5 days per week. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	vomiting] states wants to go to the hospital, T. 97.5, P.106, R18, BP 150/92 SPO2 97% room air, accu-check [test for blood sugar level] 192, Unit Manager informed, aprox [approximately] 2300 [11:00 P.M.] report called to [local hospital] [Registered Nurse] 911 called 2305 EMS here to transport resident to [local hospital emergency room]...." A Emergency Room Physician's Report, dated 4/23/22, indicated "...History of Present Illness: coming in for intractable [continuous] nausea and vomiting. She has been sick for 4 days with nausea and vomiting and she always has diarrhea. She feels dehydrated. They have been giving her Zofran and she is not able to stop vomiting. She does have diabetes, but does not recall ever being diagnosed with gastroparesis [a condition that can cause the stomach from emptying properly] ... Reexamination/Reevaluation: Patient was found to be hypokalemic [low potassium]. This was replaced orally. Patient has required numerous different doses of nausea medication. Patient was found to be profoundly hypomagnesemic [low magnesium] as well. This most likely explains her subtle EKG [Electro Cardiogram] changes with some slurring of the ST segments. This will be replaced IV [intravenously]. She was also given IV doses of potassium. She is admitted..." During an interview, conducted with the Director of Nursing (DON) on 5/4/22 12:30 P.M., she indicated the ordered STAT labs were not drawn prior to the resident going to the hospital. 2. The clinical record for Resident E was reviewed on 5/4/22 at 2:00 P.M. Diagnoses included, but were not limited to: type 2 diabetes mellitus with diabetic neuropathy, unspecified and chronic kidney disease, stage 3, unspecified.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's Progress Note, dated 4/15/22 at 9:25 A.M., indicated "... Seen for confuse and fall. Pt. [patient] said she fell [sic] backward tying to sit down on her WC [wheelchair] and feel back pain. She denies loss level of conscious. She not oriented, confused and delusional are her baseline. No new behavior. She up wandering the halls no new behavior constantly pacing the halls and seeking elopement. She demented and difficult to direct...she still at baseline confuse from her dementia. She appears to be in no distress...Plan: 15. confused- obtain routine urinalysis, CBC, [complete blood count], BMP [basic metabolic panel - electrolytes]. A Lab Results Report, with a collection date of 4/19/22 at 5:15 A.M., was reported to the facility, on 4/21/22 at 5:34 P.M. Results were as follows: Basic Metabolic Panel: Sodium: 144 - within normal range Potassium 4.9 - within normal range Chloride 111 - High (normal 97-107) Carbon Dioxide: 20 - Low (normal 22-26) BUN: 69- High (normal 8-21) Creatine: 2.5 High (normal 0.6-1.2) BUN/Creatine Ratio: 28 - High (6-22) Complete Blood Count White Blood Cell: 4.4 - Low (normal 4.5-11) Red Blood Cell: 3.38 - Low (normal 4.5-5.5) Hemoglobin: 10.2 - Low (normal 12-18) Hematocrit: 31.3% - Low (normal 37-50%) U/A: Problem: No Specimen Resolution: No urine specimen received for testing. Please have a new urine specimen recollected with a new lab order for UA with culture if indicated.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A Progress Note, dated 4/21/22 at 12:52 P.M., indicated "...Lab results received and BUN [Blood Urea and Nitrogen, a test that monitors kidney function] high. Per NP [Nurse Practitioner] resident is dehydrated. NP started IV in her left forearm running normal saline at 80 ml/hr...."

A Progress Note, dated 4/21/22 at 1:11 P.M., indicated "16. AKI [Acute Kidney Injury] start ns [normal saline] 0.9% at [sic] 80ml/hr x 3 liter.

A Urinalysis Report with a collection date of 4/26/22, was provided on 5/5/22 at 2:00 P.M. by the Director of Nursing. The urinalysis was negative for a Urinary Tract Infection. During an interview, conducted at that time, she indicated labs were not drawn daily. The corporate office was evaluating the laboratory company they currently used.

3. The record for Resident M was reviewed on 5/4/22 at 10:00 A.M. Diagnoses included, but were not limited to: type 2 diabetes mellitus with foot ulcer, unspecified open wound, left wound subsequent encounter, without type 2 diabetes mellitus with ketoacidosis without coma.

A Physician's Progress Note, dated 4/6/22 at 2:49 P.M., "...Pt. [Patient] was d/c [discharged] from Hospital with a dehiscence abdomen wound. He has a mid abdomen surgical wound that has some pus drainage by his umbilical. He has a hx [history] of MRSA [Methicillin-resistant Staphylococcus aureus, a bacterial infection]. He was d/c then from [hospital name] for cholecystectomy and repair of a cholecystoduodenal fisula. since then he had drainage he is having his wound change daily. He was noted to have acute cholecystitis with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	perforation of intra abdominal abscesses with secondary bacterial peritonitis. His incision then pack with wound care and abx [antibiotics] [name of physician] for surgery. Plan: obtain cbc, bmp, sed rate, crp [laboratory tests that are used to determine if a infection is present]. An Order Summary Report, dated April 28, 2022 at 11:34 A.M., indicated "...Obtain lab cbc, cmp, sed rate on 4-19-22 and wound culture today or asap according to lab schedule one time only for 4 days. Order Date: 4/14/22, Start date 4/14/22 End Date 4/18/22...Prescriber entered...." A Physician's Progress Note, dated 4/19/22 at 12:38 P.M., indicated "...seen for wound care . His wound culture got missed we will reorder the wound culture. His surgeon was notified and are aware...." The Treatment Administration Record, dated 4/1/22-4/30/22, indicated "...obtain lab cbc, cmp, sed rate, on 4-19-22 and wound culture today or asap [as soon as possible] according to lab schedule...." The Treatment Administration Record, dated 4/1/22-4/30/22, indicated "...please obtain wound culture stat...." 4/19/22 was left open all other squares in the month were x'd out however, the order itself was not dated. A Physician's Progress Note, dated 4/21/22 at 4:54 P.M., indicated "...lab review. Still pending wound culture got missed. His surgeon was notified and are aware. We are pending wound cultures. His upper abdomen wound is with some pus and erythema on the upper wound with a small dehiscence notice. Pt. says his wound care were hit or missed on some days. He has a mid			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	abdomen surgical wound that had some pus drainage by his umbilical and was d/c from hospital recently. He has hx of MRSA. He was d/c then from [name] for cholescystectomy and repair of a cholecystoduodenal fisutla. since then he had drainage and having his wound change daily. He was noted to have acute cholecystitis with perforation of intraabdominal abscessed with secondary bacterial peritonitis. A Progress Note, dated 4/22/2022 at 12:32 P.M., indicated "...Resident had wound culture that was to be picked up on 4/21/22. Called [lab] and LM [left message] that culture was not picked up an that they need to pick it up ASAP. NP notified that culture wasn't picked up and that this writer called and emailed [lab] to let them know that wound culture still needs to be collected...." A Lab Results Report, dated 4/22/2022 at 12:31 P.M., indicated "...Culture, Wound Heavy Growth Methicillin Resistant Staphylococcus Aureus...." A Lab Results Report, dated 4/30/22 at 2:36 P.M., indicated "... Collection Date: 4/26/22...Reported Date: 4/30/22...Culture, Wound: Heavy Growth Methicillin Resistant Staphylococcus Aureus...." During an interview with the Nurse Practitioner (NP) on 4/28/22 at 2:41 P.M., he indicated what happened with Resident M was that he originally had a wound infection and started him on an antibiotic before the wound culture came back. He then went out to a hospital for treatment and came back. He developed symptoms of infection again, but this time, in speaking with the Primary Care Physician, he was given the directive to wait until a culture of the wound was obtained with results before starting treatment. He indicated the delay from 4/13/22 to 4/22/22 to start treatment was an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unacceptable time frame. 4. The record for Resident N was reviewed on 5/4/22 at 10:30 A.M. Diagnoses included, but were not limited to: chronic kidney disease, stage 3, unspecified, chronic systolic (congestive) heart failure, personal history of COVID-19, type 2 diabetes mellitus without complications, and excoriation self-picking disorder. A Physician's Progress Note, dated 4/1/2022, indicated "...seen for follow up on readmission and med refill. She has ongoing wound care her recent arterial doppler showed no evidence of significant stenosis. the wound nurse is continuing care and ask to see the pt. [patient]] for possible una boot to help with the healing process. Her wounds are constantly oozing with serous fluids. She was sent [sic] for worsen left leg pain and cellulitis and AKI [Acute Kidney Injury]...she has been told that this wound are not likely going to heal d/t [due to] her comorbidities. She constantly in and out of the hospital d/t her wounds...Plan: 10: ckd [chronic kidney disease] keep monitoring labs. Continue monitoring lab...19. Knee pain-continue steriods as order obtain cbc, bmp...." A Progress Note, dated 4/13/22 at 11:44 A.M., indicated, "...BMP & BNP were drawn 4/5/22 and insufficient quantity. Notified resident and NP. New order to draw tomorrow 4/14/22...." A Nurse Practitioner (NP) Progress Note, dated 4/14/22 at 11:55 A.M., indicated, "...Resident seen for lab review and follow up on pt. [patient] care. Pt. is constantly itching at her wound and traumatizing her wound. Psych made some changes, the una boot did help with healing according to wound nurse. She will not keep the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dressing on long enough, she is guarded about palliative care. Her wounds are not oozing with serous fluids. her bnp [test that measures for congestive heart failure] elevated and bun and cr [kidney function tests] She has a hx [history] of cellulitis and AKI [Acute Kidney Injury] upon admission she has tricompartmental OA [Osteoarthritis] of the knee. pt. has no concern but she having trouble with standing. She been told that this wound are not likely going to heal d/t her comorbidities. She constantly in and out of hospital d/t her wounds...Plan: Recheck labs cbc, bmp, sed rate [inflammation level] bnp...." A Progress Note, dated 4/21/22 at 8:23 A.M., indicated "... Resident was found by C.N.A. on the floor during first am round. She was on her back and could not verbalize what she was doing or how she fell. NP evaluated and provided orders to transfer for evaluation related to labs, COC, AMS, Resident was assisted off the floor with hoyer and 4 staff into the bed. [Ambulance company] called to transport...." A Emergency Room Physician's Report, dated 4/21/22, indicated "...History of Present Illness: Patient has a known UTI but nursing staff states has been more confused. Patient has weeping wounds to her legs which are chronic for her per the nursing home report no history of nausea and vomiting. Assessment/Plan: AMS (altered mental status), ACF (acute renal failure), Dehydration, UTI sysmptoms...." A [Local Hospital] Extended Care Facility Patient/Resident Transfer Form- Physicians Orders, dated 4/28/22, at 9:15 A.M., indicated "...Diagnosis Primary: Septic Shock, UTI...." During an interview with the NP on 4/28/22 at 2:41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M., he indicated it sometimes took 2 to 3 days for a STAT lab to come back. In the case of wound cultures, they should be back within 72 hours. In the case of Resident N, his wound culture was missed which delayed his treatment because the primary care physician did not want to treat until he knew what the culture said. Urinalysis results sometimes took 3 to 5 days to come back. He indicated it felt like he was being set up to fail as a practitioner because the lab did not provide the labs he needed in a timely manner. On 5/4/22 at 4:06 P.M., the Interim Executive Director provided a laboratory contract titled, "A Nursing Facility Laboratory Agreement", dated 9/28/2018, and indicated this is the contract currently being used by the facility. The contract indicated "... Responsibilities of [lab]: c. [lab] will provide STAT (life threatening situation) service for clinical lab services 24 hours per day, 365 days per year. Laboratory STAT testing will be reported within 5 hours. The menu of available STAT tests is attached...." The menu of available STAT tests had not been provided by the Interim Executive Director at the time of exit. On 5/4/22 at 4:06 P.M., the Interim Executive Director provided a laboratory contract titled, " Laboratory and Radiological Services and Results Reporting" , with a revision date of 1/18/22 and indicated this was the policy currently being used by the facility. The policy indicated "...The purpose of this policy is to provide guidance for reporting of results from laboratory, radiology, and other diagnostic services to the ordering practitioner. 1. Overview: The facility will secure laboratory and radiological services that meets the needs of the resident population served. c. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility will have an on-going written agreement with a qualified laboratory (ies) and radiology units to perform services to meet the needs of the resident population. Facility Receiving Reports: a. The facility will collaborate with the lab and /or radiology unit to provide reports to the facility in a timely manner: iv: the facility will review the results in a timely manner and notify the ordering physician/provider of the results and document reporting and follow up care in the progress notes...." 5. On 5/2/22 at 9:30 A.M., the Clinical records for Resident G were reviewed. A Progress Note written by the facility Nurse Practitioner (NP), dated 4/12/22 at 1:06 P.M., indicated, "... Encounter Reason Acute Visit Chief Complaint (CC) cough and cold...seen for cough and cold. [Resident G] mentioned it started last night...Per Staff she is negative for covid on the quick antigen test..." A Progress Note written by the facility Nurse Practitioner, dated 4/14/22 at 3:22 P.M., indicated,"... Encounter Reason Acute Visit Chief Complaint follow up on pt cough...seen for follow up on pt cough and cold and chest x ray. Her X-ray wnl... Per Staff she is negative for covid on the quick antigen test her pcr is pending.. Acute upper respiratory infection, unspecified Plan: continue Fexofenadine daily isolation for droplet covid pending pcr covid screen result..." A late entry Nurse's Note dated 4/14/2022 at 4:48 P.M., indicated,"Resident continues to remain in isolation. CXR [chest x-ray] results negative. NP aware of CXR results. PCR obtained and sent out..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A late entry Nurse's Note dated 4/16/2022 at 4:09 P.M., indicated, "PCR test results are negative..." A review of Resident G's Order Audit Report dated 4/12/22 at 1:04 P.M., indicated the Nurse Practitioner ordered the facility to, "obtain stat [immediately] pcr covid screen..." A review of Resident G's Order Audit Report dated 4/14/22 at 4:49 P.M., indicated the facility Medical Director ordered the facility to, "obtain stat pcr screen with upper respiratory swab combo kit..." On 5/4/22 at 4:06 P.M., the document entitled "Nursing Facility Laboratory Agreement", effective date 9/28/18, was provided by the Interim Executive Director. The agreement indicated,"... [lab] will provide STAT (life threatening situation) service for clinical lab services 24 hours per day, 365 days per year. Laboratory STAT testing will be reported within 5 hours..." During an interview on 5/03/22 at 3:00 P.M. with the Director of Nursing, she indicated Resident G complained of cold symptoms on 4/11/22 and a POC (Point of Care) COVID-19 test was done with negative results. The Director on Nursing indicated on 4/12/22 the resident continued with symptoms of a head cold so the Nurse Practitioner ordered a STAT pcr test. The Director of Nursing indicated the resident was not tested until the facility physician ordered a second STAT pcr test on 4/14/22. The Director of Nursing indicated the STAT lab was delayed and should have been completed within 5 hours of the original order on 4/12/22. This Federal tag relates to Complaints IN00378735, IN00378881, and IN00379238.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-49(a)			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4)(c) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. Based on interview and record review, the facility failed to provide residents with a designated Infection Preventionist who worked at least part-time in the roll as Infection Preventionist. This deficient practice had the potential to affect 82 of 82 residents who resided in the facility.	F 0882	F 882 Infection Preventionist Qualification Role 1) The facility has designated an Infection Preventionist who will be working at least part time role. 2) All residents have the	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During an interview on 4/29/22 at 11:08 A.M., the Executive Director indicated the facility had not had a nurse in the position of Infection Preventionist (IP), since the previous IP left the facility on 4/14/22. The previous IP had been employed in that role for about 2 weeks before resigning. The Executive Director indicated there was a Licensed Practical Nurse (LPN) in the facility who was certified in infection control, but she was not working in the capacity of IP full time or part time. The Executive Director indicated the facility should have a Certified Infection Preventionist working in the roll as IP, but the facility did not currently have that roll filled. During an interview on 4/29/22 at 1:17 P.M., the Director of Nursing indicated the previous IP's last day was on 4/14/22, and the facility has not had anyone in the roll of Infection Preventionist since 4/14/22. The facility had a nurse who was certified in Infection Control, but she was not working in the roll of Infection Preventionist. The facility should have a Certified Infection Preventionist working in the roll as IP. A policy titled "Policy and Standard Procedures...Infection Prevention Program," dated 3/09/20 and revised 3/05/21,was provided by the Division Director of Clinical Operations, on 5/05/22 at 1:00 P.M., and was reviewed at that time. The policy indicated, "...Procedure...iii. An IP/designee will coordinate and be responsible for surveillance and reporting of infectious outbreaks. 1. The IP designee is a nurse in the facility with knowledge of the geographic population and with the rules and regulations of LTC [Long Term Care] infectious concerns..."		potential to be affected with alleged deficient practice. No harm has occurred due to alleged deficient practice. 3) The Corporate Nurse will educate the Executive Director and Director of Nursing on the requirement to provide residents with a designated Infection Preventionist, who has completed specialized training in Infection Control, who works at least part-time in the role. 4) The Director of Nursing or designee will validate that the facility has a designated Infection Preventionist, who has completed specialized training in Infection Control, who works at least part-time in the role. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a clean, safe, and sanitary environment related to long coiled wires, wet floors from plumbing leaks, wall gouges, and loose or uncovered electrical wall receptacles on 3 of 4 Units. (100, 200, and 400 Units) Findings include: During an environmental tour of the facility, on 5/05/22 from 12:05 P.M. to 12:45 P.M., the following was observed: 1. 100 Unit a. In Room 103 a large amount of excess black cable wire was coiled on the floor between the wall heater and the closet. b. In Room 105, a large amount of excess black cable wire was coiled on the floor at the foot of bed 1. c. In Room 113, there was a pool of green substance approximately 6 inches wide by 16 inches long behind the dresser next to the bathroom door. The bathroom floor behind the toilet was wet with a green fluid along the baseboard. On 5/05/22 at 12:30 P.M., an interview with Licence Practical Nurse (LPN) 4 indicated the toilet was leaking in room 113 and was leaking	F 0921	F 921 Safe Functional Sanitary Comfortable Environment 1) Room 103, the large cable wire was removed from the floor. The residents residing in this room were not harmed due to alleged deficient practice. Room 113, the room was cleaned of the green substances identified behind the dresser and in the bathrooms baseboard behind the toilet. Leaking toilet was addressed and fixed. The residents residing in this room were not harmed due to alleged deficient practice. Room 205, the room was cleaned to remove the odors. The residents residing in this room were not harmed due to alleged deficient practice. Room 206, television was secured. The residents residing in this room were not harmed due to alleged deficient practice. Room 404, plumbing in bathroom and gauges have been addressed and corrected. The residents residing in this room were not harmed due to alleged deficient practice. Room408, cable precet cover was attached to the wall, black cable was corrected, white cable	06/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	under the bathroom wall into the resident's room. 2. 200 Unit a. In Room 205, a strong foul urine odor was noted and reached to the area outside the room. b. In Room 206, the television was noted to be off the television wall mount unit, and rested on the dresser and leaning against the wall. 3. 400 Unit a. In Room 404, a gouge was noted to the right of the entry door approximately 5 inches wide by 16 inches long. In the bathroom, a pink rectangular plastic basin was noted under the sink and partially filled with water from broken sink plumbing. There was a white bath towel laying on the floor at the base board under the sink that was completely saturated with water. When the sink was turned on, the water flowed freely into the plastic tub. A hole was observed in the drywall under the sink approximately 5 inches long by 5 inches wide. There were no warning signs, tape, or postings to alert staff, residents, or visitors of broken sink plumbing. On 5/05/22 at 12:10 P.M., an interview with CNA 2, indicated the sink in room 404 had been broken for nearly 2 weeks and had been reported to maintenance. A review of Work Order #4767 was provided by the Interim Executive Director on 5/4/22 at 3:28 P.M., and reviewed at that time. The Work Order was created on 4/25/22 at 8:02 A.M. and indicated the sink was off the wall in room 404. b. In Room 408 the cable precept cover was not		removed from the room. The residents residing in this room were not harmed due to alleged deficient practice. Room 410, 4 receptacles were removed from the room. The residents residing in this room were not harmed due to alleged deficient practice. Room 412, 4 receptacles were removed from the room. The residents residing in this room were not harmed due to alleged deficient practice. 2) All residents have the potential to affected by alleged deficient practice. The Maintenance Director or designee will audit all units to ensure a safe, functional, sanitary, and comfortable environment on or before the date of compliance. Any items identified of concerns will be corrected. 3) The ED will educate the Maintenance Director on the process of environmental rounds, TELS and the timeliness of completing work orders. 4) Maintenance will audit 14 resident rooms x 4 weeks, then 7 resident rooms weekly x 4 weeks, then 10 resident rooms monthly x 4 months to ensure all resident rooms/environment remains safe, functional, sanitary, and comfortable.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attached to the wall behind bed 1, and was hanging loosely from a black cable that went from the television to into the wall. The black cable was noted to have several coils wrapped on the floor at the foot of the bed. A white cable was also noted to be coiled next to the black cable creating a heap of coiled cables. c. In Room 410, 4 receptacles were noted on the wall at bed height level at approximately 36 inches. All of the receptacle were open with none having protective covers. The receptacle closest to the room door had the plastic cover broken on the bottom area and exposed the box behind. d. In Room 412, 4 receptacles on the wall to the left of the entry door were without protective covers. The receptacle closest to the door did not have a plate cover. The receptacle closest to the window was broken away from the wall. This Federal tag relates to complaint IN00378592. 3.1-19(f)(5)(n)		The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	