

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

PRINTED: 06/03/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155496	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2022
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 333 W MISHAWAKA RD ELKHART, IN 46517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00380579, IN00380246, IN00379976 and IN00379763.</p> <p>Complaint IN00380579 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00380245 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00379976 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00379763 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: May 26 and 27, 2020</p> <p>Facility number: 000523 Provider number: 155496 AIM number: 100266930</p> <p>Census Bed Type: SNF/NF: 84 Total: 84</p> <p>Census Payor Type: Medicare: 7 Medicaid: 65 Other: 12 Total: 84</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 6/2/22.</p>	F 000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.