STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING _____ B. WING _____	R-C 07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE CENTER	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}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00374814 IN00376068 and IN00376741 completed on April 6, 2022. This visit was in conjunction with the PSR to the Investigation of Complaints IN00368256 IN00370151 IN00371647 and IN00372368 completed on February 18, 2022. This visit was in conjunction with the (PSR) to the Investigation of Complaints IN00378592 IN00378735 IN0037881 IN00378854 and IN00379238 completed on May 5, 2022. This visit was in conjunction with the PSR to the Investigation of Complaint IN00382807 completed on July 1, 2022. Complaint IN00374814 - Corrected. Complaint IN00376068 - Corrected. Complaint IN00376741-Corrected. Complaint IN00368256 - Corrected. Complaint IN00370151- Corrected. Complaint IN00371647- Corrected. Complaint IN00372368 - Corrected. Complaint IN00378592 - Corrected. Complaint IN00378735 - Corrected.	{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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING _____ B. WING _____	R-C 07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE CENTER	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}	Continued From page 1 Complaint IN00378881 - Corrected. Complaint IN00378854- Corrected. Complaint IN00382807 - Corrected. Survey dates: July 25 and 26, 2022 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 67 Other: 4 Total: 76 Valley View Healthcare Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00374814 IN00376068 and IN00376741. Quality review completed 8/8/22.	{F 000}		