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	12/01/2021

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/01/21 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Emergency Preparedness survey, Valley View Healthcare Center, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 80. Quality Review completed on 12/02/21	E 0000	K000 Attached is the plan of correction for Life Safety Code with Emergency Preparedness Survey conducted at Valley View Healthcare Center on December 1, 2021. The facility is respectfully asking for a desk review regarding this survey.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/01/21 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Life Safety Code survey, Valley View Healthcare Center was found not in compliance	K 0000	K000 Attached is the plan of correction for Life Safety Code with Emergency Preparedness Survey conducted at Valley View Healthcare Center on December 1, 2021. The facility is respectfully asking for a desk review regarding this survey.	

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 01 B. WING	12/01/2021

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
	with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The 500, 600, and 700 Hall Units, which are in the southern portion of the facility, are decommissioned and do not have any residents living in them. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility is fully protected by a 75 kW natural gas generator. The facility has a capacity of 94 beds dually certified for Medicare and Medicaid. At this survey the facility had a census of 80. All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered. Quality Review completed on 12/02/21			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 smoke barrier doors in the 600-hall. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff in the 600-hall. Findings include: Based on observation with the Maintenance Director on 12/01/21 at 12:32 p.m., the set of smoke barrier doors to the 600-hall was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the Maintenance Director agreed the smoke doors were equipped with latching devices, but the doors did not latch when tested. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0100	K 100 1. General Requirements – Maintenance Director adjusted the smoke barrier doors on 600 hall to achieve the positive latch when closed. Executive Director in-serviced the Director of Maintenance on the requirement to maintain latching hardware on smoke barrier doors. 2. Residents have the potential to be effected by the deficient practice. The Director of Maintenance will complete the required smoke barrier door checks for positive latch. 3. The Executive Director will review the results of the smoke barrier door checks during monthly QAPI for any issues identified for the door closing checks conducted by Maintenance. 4. The results of these audits will be sent to the Facility Safety Committee for follow-up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date December 16, 2021	12/16/2021
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 25 residents in the 200-hall. Findings include: Based on an observation with the Maintenance Director on 12/01/21 at 11:01 a.m., in the 200-hall by room 211 a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the cart to be moved out of the hall during an emergency. Based on an interview at the time of observations, the Maintenance Director agreed the PPE cart was not equipped with wheels. The finding was reviewed with the Administrator and Maintenance Director during the exit	K 0211	K211 1. Means of Egress – The PPE cart by room 211 without wheels was removed on 12/1/21. The Executive Director in-serviced the Director of Housekeeping on the requirement that a corridor must be wheeled and is limited to following: Equipment in use, medical equipment not in use, patient lift and transport equipment. 2. Residents have the potential to be affected by this deficient practice. The Executive Director or Director of Maintenance will conduct expected and unexpected inspections of the hallways to ensure that no none wheeled objects are left in the corridor. 3. The Executive Director will meet with the Directors of Housekeeping and Maintenance to review audits that are tracking the results of the rounds. The Directors of Housekeeping and Maintenance have been in-serviced on the requirement to keep the means of egress free from obstructions. The Executive Director will review the results of the audits and the Monthly QAPI meeting. 4. The results of these audits will be reviewed at the safety	12/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	conference. 3.1-19(b)		committee for follow-up as needed. The Safety Committee will monitor for 3 months longer if substantial compliance is not maintained. 5. Completion date 12/16/21	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and Interview, the facility failed to ensure 1 of 10 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction,	K 0222	K 222 1. Egress Doors – The Executive Director in-serviced the Director of Maintenance on requirement LSC 7.2.1.6.1 (3) which states an irreversible process shall release the lock in	12/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 15 residents that would use the courtyard exit during an emergency. Findings include: Based on observation during a tour of the facility with the Maintenance on 12/01/21 at 11:30 a.m., the courtyard smoking exit door was equipped with a 15 second delayed egress. When the exit door was tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance Director tried 4 times to activate the delay egress and stated the delayed egress was not working and will need to be repaired. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		direction of egress within 15 seconds. Contractor SafeCare reprogrammed code alert at the smokers' door on 12/2/21. 2. Residents have the potential to be affected by the deficient practice. The Executive Director or Director of Maintenance or designee will conduct expected and unexpected inspections of all egress doors to ensure the 15 second delay is working correctly. 3. The Executive Director will meet with the Director of Maintenance to review audits that are tracking requirements of LSC 7.2.1.6.1 (3) quarterly to ensure continued adherence in QAPI. Director of Maintenance has been in-serviced on the requirement to install delayed egress locking requirement. 4. The results of the audits will be reviewed at the Safety Committee for follow-up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion date 12/16/21.	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure the corridor doors to 5 of 5 hazardous area enclosure were self-closing and kept in the closed position. This deficient practice could affect staff in the 500-hall. Findings include: Based on observation with the Maintenance Director on 12/01/21 at 12:10 p.m., rooms 501, 502, 503, 504, and 505 were larger than 50 square feet and contained over 15 boxes of supplies and other combustible storage making each room a hazardous area. All five doors to the rooms were equipped with a self-closing device, but the self-closing device would not fully close or keep each door in the closed position. Based on interview at the time of observation, the Maintenance Director agreed all five rooms were hazardous storage areas, and the self-closing device on each door was not functioning properly. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0223	K223 1. Doors with Self Closing Devices – Executive Director has in-serviced Director of Maintenance on the requirement that doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device. The self-closing devices on doors 501, 502, 503, 504, and 505 have been repaired and are in good working order. The doors now close and latch into the frame. 2. Residents have the potential to be affected by this deficient practice. The Executive Director or Director of Maintenance or designee will conduct expected and unexpected inspections of all doors that have self-closing device on them to ensure they are all working properly.	12/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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. The Executive Director will meet with the Director of Maintenance to review audits that are tracking adherence to requirements of LSC Section 7.2.1.8.2 quarterly to ensure continued adherence. Director of Maintenance has been in-serviced on the requirement and audits will be reviewed in monthly QAPI. 4. The results of these audits will be reviewed by the facility Safety Committee for review and follow-up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion date 12/16/21	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0712	K712 1. Fire Drills – The Executive Director has in-serviced the Director of Maintenance on LCS 19.7.1.4 through 19.7.1.7 requirement that the facility	12/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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: Based on records review with the Maintenance Director on 12/01/21 at 10:01 a.m., all third shift (10:00 p.m. to 06:00 a.m.) fire drills took place around 11:00 p.m. This condition does not allow fire drills on third shift to be conducted at unexpected times. Based on interview at the time of record review, the Maintenance Director agreed third shift drills took place around 11:00 p.m. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		conduct quarterly fire drills at unexpected times under varying condition on third shift for 4 of 4 quarters. 2. Residents have the potential to be affected by the deficient practice. The Executive Director or Director of Maintenance will conduct expected and unexpected fire drills in accordance with LSC 19.7.1.6 on each shift. 3. Executive Director will meet with the Director of Maintenance to review fire drill log quarterly. The Director of Maintenance has been in-serviced on Fire Drill policy and their documentation has been reviewed in QAPI. 4. The results of the audits will be reviewed in Safety Committee for follow-up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Compliance date 12/16/21	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 15 residents in the courtyard. Findings include: Based on observation with the Maintenance Director on 12/01/21 at 11:10 a.m. and 12:01 p.m., in the courtyard resident smoking area a plastic trashcan contained combustible items and cigarette butts. Also, from the laundry exit to the staff smoking area there were over 80 cigarette butts disposed on the ground around the exit and smoking area. Based on interview at the time of observations, the Maintenance Director agreed there were cigarette butts on the ground and in a trashcan in the aforementioned locations.	K 0741	K741 1. Smoking Regulations – All cigarette butts have been collected from the ground near both of the designated smoking areas. Residents and staff that are known to smoke have been educated on the use of the metal or noncombustible container with self-closing cover devices. 2. Residents have the potential to be effected by the deficient practice. The Executive Director or Director of Maintenance or designee will conduct expected and unexpected inspection of all smoking areas to ensure no smoke butts are present and that smokers are using ashtrays.	12/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		3. Executive Director will meet with the Director of Maintenance to review audits that are tracking adherence to requirments of 18.7.4 (3) to ensure continued adherence. Director of Maintenance has been in-serviced on the requirement and the information will be reviewed in QAPI. 4. The results of these audits will be reviewed with the Safety Committee for follow-up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion date 12/16/2021	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained for 2 of 2 electrical panels in main mechanical room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space	K 0911	K911 1. Electrical Systems – The Executive Director has in-serviced the Director of Maintenance on NFPA 70, Article 110.26 that access and working space shall be provided and maintained about all electrical equipment to permit	12/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90 degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could 30 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 12/01/21 at 10:51 a.m., the electrical panels in the main electrical room was blocked from access with ladders stored in front of the panels. Based on interview at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of the electrical panels. The finding was reviewed with the Administrator and Maintenance Director during the exit conference.		ready and safe operation and maintenance of such equipment. The ladders that obstructing the electrical panels were removed and relocated to another secure area of the building on 12/1/21. 2. Residents have the potential to be affected by the deficient practice. The Executive Director or Director of Maintenance or designee will conduct expected and unexpected tours of the electrical rooms. 3. Executive Director will meet with the Director of Maintenance to review tour findings and documentation monthly. The audits will be brought to QAPI. 4. The results of these audits will be reviewed with the Safety Committee for follow-up as needed. The Safety Committee will monitor for 3 months or longer if substantial compliance is not maintained. 5. Completion Date 12/16/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	12/01/2021

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
	3.1-19(b)			