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

FORM APPROVED
OMB NO. 0938-0391

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	09/07/2021

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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00361671. Complaint IN00361671 - Substantiated. Federal/state deficiency related to the allegation is cited at F686. Survey dates: September 3 & 7, 2021 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 5 Medicaid: 78 Other: 3 Total: 86 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on September 15. 2021.	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State 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 non-compliance cited during survey on September 3rd and 7th 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 00 B. WING	09/07/2021

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
	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review and interview, the facility failed to follow their policy related to assessing a wound for 1 of 3 residents reviewed for wounds. (Resident B). Findings include: A clinical record review was completed on 9/3/2021 at 11:16 A.M., and indicated Resident B's diagnoses included, but were not limited to: congestive heart failure, hypertension, cardiomegaly, chronic kidney disease, and history of COVID. A Nurse Practitioners' note, dated 5/27/2021, indicated Resident B had an edematous leg ulcer possible venous or arterial with foul odor. Inspection of skin: overall bilateral leg ulceration and foul odor. Plan: 1. Leg ulceration/wound consult wound nurse start Bactrim DS (antibiotic) twice a day x 10 days, obtain arterial/venous Doppler. A Nurse Practitioner's note, dated 5/28/2021, indicated the "...foot is very tender to touch to the phalanges [toes]. The Dopplers are still pending, his leg was washed and ammonia lactate was applied. [Name of primary physician] rounded and suspected a fungal infection - will obtain wound cultures and continue with lab work	F 0686	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Skin assessment completed by DON and wound nurse for the resident found to be affected. Documentation has been reviewed, and wound MD has evaluated the residents skin conditions, and reviewed treatment orders.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**All residents will be evaluated to determine risk factors by using the Braden observation tool. For those residents identified at risk for development of pressure ulcers, individualized prevention interventions will be defined on the resident's care plan and implemented. For all residents currently identified with pressure ulcers, treatment orders will be reviewed by wound nurse and	09/29/2021

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	09/07/2021

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
	as well. The podiatrist is to follow to remove cuticles. Inspection of skin: overall bilateral leg ulceration and foul odor. White plaque bilaterally over the dorsal [upper] aspect of the ft [foot] over the 1,2,3 digits. Plan: leg ulceration/wound consult, wound nurse, start Bactrim DS [antibiotic] twice a day x 10 days, Clotrimazole [antifungal] Cream 1% every day and wound culture...." A weekly skin check form completed by a nurse, dated 5/31/2021, indicated the skin was normal in color, warm and dry. Treatment continues to bilateral lower extremities. A Nurse Practitioners note, dated 6/1/2021, indicated the resident allowed staff to swab his foot wounds. "The arterial Doppler is pending. Resident B's edematous leg ulcer appears somewhat better from last week. The resident continues to have pain on bilateral phalanges with a foul odor with possible necrotic [dead tissue] toes. The podiatrist was notified in the hallway and they will visit the resident today. White plaque bilaterally over the dorsal aspect of the ft over the 1,2,3 digits. Plan: consult podiatrist." A podiatrist note, dated 6/1/2021, indicated "...the resident complains of painful nails to bilateral feet. Wound care doctor just left and had removed bilateral dressings. Stated they had been applying Lotrimin cream bilateral. Nails are noted to be thick, friable, dystrophic, discolored with incurvated borders and tenderness to slight touch on digits-1,2,3,4,5 to right foot and 1,2,3,4,5 to left foot. The 5th nail of the right foot was growing into the 4th digit causing a wound. Wound is macerated and there is drainage present with SOL. Unsure if there is		wound MD to ensure that appropriate orders are in place and modify as indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**The DON/designee will assess all residents' weekly changes in skin conditions as well as to identify risk indicators quarterly and with change of condition. For those residents identified at high risk for development of pressure ulcers, individualized prevention interventions will be defined on the resident's care plan, implemented and revised as appropriate. The DON/designee will educate licensed nursing staff on accurate completion of the Braden Observation Tool and Weekly Skin Check Tool.**How the corrective action will be monitored to ensure the deficient practice will not recur.**DON/designee will audit Braden observations and weekly skin assessments twice weekly for 8 weeks, weekly x4 weeks, and then monthly for no less than three months. ="" span="">	

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	09/07/2021

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
	osteomyelitis at this time. When trimming the 5th nail of the right foot, nail was removed out of the 4th digit exposing the wound. Recommend having x-ray of 4th toe right foot to rule out possible osteomyelitis. Wound care will continue to treat as they have been with no new orders. Professional treatment of toenails is required to relieve pain, and to prevent exposing patient to health risks that may result in complications of limb due to neuropathy/peripheral vascular disease. Non-pressure chronic ulcer of other part of right foot with unspecified severity...." A weekly skin check form completed by a nurse, dated 6/7/2021, indicated there were new skin conditions or changes, ulcers or injuries. Skin is normal in color, warm and dry with brisk turgor. Treatment continues to bilateral lower extremities. No documentation present of the wound to the right 4th toe. A Nurse Practitioner's note, dated 6/8/2021, indicated active foot ulcer and inspection of pedal pulses: overall strong, equal bilaterally. Overall no edema and or cyanosis. Wound bilateral lower extremities and healing well. Active foot ulcer. Plan: leg ulceration and foot wounds continues, wound nurse and daily soaks. Clotrimazole 1% cream every day, pending wound culture, follow podiatrist and foot x-ray pending. A Nurse Practitioner's note, dated 6/10/2021, indicated the resident still complains of tenderness and some necrotic toes. The Doppler was negative. Inspection of skin: wound BLE-worsened. Foot ulcer-active. Plan: leg ulceration and foot wounds continues, wound nurse and daily soaks. Clotrimazole 1% cream			

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	09/07/2021

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
	every day, will start Keflex (antibiotic) 500 mg (milligrams) every 6 hours x 10 days and fluconzole (anti fungal) 150 mg twice daily x 10 days. Pending wound culture, follow podiatrist and foot x-ray pending. There was no documentation showing the wound to the 4th toe on the right foot was assessed. A Nurse Practitioner's note, dated 6/23/2021, indicated a follow up on the leg wounds. There is foul odor on the left foot and still had pain to the 2nd and 3rd digits with complaints of tenderness and some necrotic toes on the left foot. Plan: leg ulceration and foot wounds continue, wound nurse and daily soaks. Clotrimazole Cream 1% every day and will start Tramadol (narcotic pain medication) 50 mg twice daily. There was no documentation indicating the wound to the 4th toe on the right foot had been assessed. A weekly skin check completed by a nurse, dated 6/28/2021, indicated yes to new skin conditions or changes, ulcers or injuries since the last documented skin check. Please indicated the following: 1. New suspected pressure ulcer/DTI. 2. New non pressure skin condition. 3. Both. 4. Neither. No documentation of what the new area was. Comments/Summary: skin is normal in color, warm, and dry. Treatment continues to left buttock and bilateral lower extremities. There was no documentation indicating the wound to the 4th toe on the right foot had been assessed. A skin grid form, for a non-pressure area, dated 6/29/2021, indicated Resident B refused a wound assessment. A Nurse Practitioner's note, dated 7/1/2021, indicated active foot ulcer. Left foot tenderness to the 2nd and 3rd phalanges necrotic tissue 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	09/07/2021

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
	tenderness. Plan: Leg ulceration and foot wounds continue, wound nurse and daily soaks. Clotrimazole Cream 1% every day and continue Tramadol (narcotic pain medication) 50 mg twice daily. There was no documentation indicating the wound to the 4th toe on the right foot had been assessed. A weekly skin check completed by a nurse, dated 7/5/2021, indicated: had an open area to the left buttocks and left foot toes. There was no documentation showing the wound to the 4th toe on the right foot was assessed. A skin grid form, for non pressure area, dated 7/6/2021, indicated the resident refused a wound assessment. A Nurse Practitioner's note, dated 7/6/2021, indicated Resident B had cyanosis to the bilateral toes, left foot tenderness to the 2nd and 3rd phalanges, necrotic tissue and tenderness. Plan: leg ulceration and foot wounds continue, wound nurse and daily soaks, Clotrimazole Cream 1% every day, obtain CBC (complete blood count), bmp (basic metabolic profile), blood culture and continue Tramadol. There was no documentation showing the wound to the 4th toe on the right foot was assessed. A Nurse Practitioners' note, dated 7/9/2021, cyanosis to the bilateral toes, left foot tenderness to the 2nd and 3rd phalanges, necrotic tissue and tenderness. Foot ulcer worsened. Plan: leg ulceration and foot wounds continue, wound nurse and daily soaks, Clotrimazole Cream 1% every day. The resident refused the blood work. Will try an x-ray of the left foot. There was no documentation indicating the wound to the 4th toe on the right foot had been assessed.			

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	09/07/2021

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

A weekly skin check completed by a nurse, dated 7/12/2021, indicated yes there were skin conditions or changes, ulcers or injuries, but were not new since last documented skin check. Comments/Summary: skin is normal in color, warm and dry with brisk turgor. Treatment continues to skin tear on buttock. There was no documentation indicating the wound to the 4th toe on the right foot had been assessed.

A Nurse Practitioner's note, dated 7/12/2021, indicated the resident had a worsening foul odor on the left foot and still having pain with necrosis to the 2nd and 3rd digits. The x-ray was normal and no indication of osteomyelitis. Plan: leg ulceration and foot wounds continue, wound nurse and daily soaks, Clotrimazole Cream 1% every day and continue tramadol. There was no documentation showing the wound to the 4th toe on the right foot was assessed.

A skin grid form, dated 7/13/2021, indicated the resident had refused a wound assessment.

A review of nurses' notes dated 6/10/2021 to 7/15/2021 lacked the documentation to show the wound to the right foot 4th toe had been assessed, measured or the physician had been notified.

During an interview, on 9/7/2021 at 9:46 A.M., LPN (Licensed Practical Nurse) 2 indicated she was unaware of any area to the right toes until he had a shower the night before he went to the hospital.

During an interview, on 9/7/2021 at 10:15 A.M.., the Director of Nursing indicated she thought the area was only a fungal infection and not a wound.

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	09/07/2021

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
	During an interview, on 9/3/2021 at 12:52 P.M., LPN (Licensed Practical Nurse) 3 indicated Resident B had very dry and scaly skin on his legs and feet and there was no necrotic areas. LPN 2 indicated the resident had a shower the night before he was transferred to the hospital and there was no odor or drainage from his feet. During an interview, on 9/7/2021 at 10:37 A.M., LPN 4 indicated Resident B did not have ulcers or wounds to his legs, but had an odor from the fungal infection on his toes. LPN 4 indicated he was not notified of the wound to the right toe until the resident had gone to the hospital. LPN 4 indicated when a skin issue is found, the nurse is supposed to assess the area and make out a non pressure form or a pressure form, measure the area, and trigger a weekly skin grid form so he would be notified of a new area. On 9/7/2021 at 1:28 P.M., the Director of Nursing provided the policy titled, "Skin Care & Wound Management Overview", dated 7/2/2016, and indicated the policy was the one currently used by the facility. The policy indicated"...The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds.... The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital. Treatment: 1. Select 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	09/07/2021

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
	complete the appropriate form. a. Pressure Ulcer Documentation. Completed for all pressure ulcers. b. Skin Impairment Documentation. Complete for all skin impairment issues that require measurement to indicate if healing is occurring...." This Federal tag relates to Complaint IN00361671. 3.1-40(a)(2)			