	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	(X2) MULTI A. BUILDI B. WING	PLE CONSTRU NG <u></u>	CTION	(X3) DATE COMPL 05/06/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  333 W MISHAWAKA RD  ELKHART, IN 46517				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IC PRE TA	FIX (E. CRO	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42  Survey Dates: 05/0  Facility Number: 0  Provider Number: 1002  At this Emergency I  View Healthcare Ce compliance with En Requirements for M Participating Provided 483.73	5/25 - 05/06/25  00523 155496 266930  Preparedness survey, Valley enter, was found in substantial mergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR  certified beds. At the time of us was 81.	E 0000	plan cons of pr or al on th Plan exec requ and Corr resp non- surv this i prov com	paration and execution of of correction does not stitute admission or agree rovider of the truth of the fleged or conclusions set to estate of Deficiencies. To of Correction is prepared to the solely because it is irred by the position of Ferstate Law. The Plan of ection is submitted in order ond to the allegation of compliance cited during the ey process. Please acceptant of correction as the ider's credible allegation of pliance. The facility is ectfully requesting a deskey.	ment facts forth The I and deral er to he	
E 0025 SS=C Bldg	Arrangement with  Based on record rev failed to ensure eme and procedures inch arrangements with o providers to receive limitations or cessat the continuity of ser accordance with 42	3.113(b)(5), 441.184(b) Other Facilities riew and interview, the facility ergency preparedness policies ude the development of other LTC facilities and other residents in the event of ion of operations to maintain evices to LTC residents in CFR 483.73(b)(7). This ould affect all occupants.	E 0025	What according foun deficing admired mutures and the most of the m	p=""> it corrective action(s) will omplished for those resided to have been affected being the practice: The inistrator has reviewed the ual aid agreement and seew and updated to current other residents having the ntial to be affected by the deficient practice will be tified and what corrective	ents by the e nt for i.	07/09/2025
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

Olivia Shirley Executive Director 05/25/2025

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any deflencystatement enough with an assertsk (\*) denotes a deflective which the institution may be excused from correcting providing it is determined the safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VTD921 Facility ID: 000523 If continuation sheet Page 1 of 28

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155496		A. BUILDING B. WING	SNSTRUCTION	COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Based on records review and interview with the Executive Director (ED) and Maintenance Director (MD) on 05/05/25 at 12:05 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review but the agreements were several years old, dating back to 11/22/20. Based on an interview during records review, the ED stated agreements were still in force and was unaware of the requirement to update the agreements regularly.  This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not rece Executive Director/Maintenance Director have been educated to review facility listing identificate when reviewing Emergency Preparedness Program plan's every 12 months in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director review the Emergency Preparedness Program at least annually.  How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place: Annual review of the facility listing in the Emergency Preparedness Program was added to the QAPI.	be to DATE  be to Descriptions  ce to to to st will be ent at I be of
K 0000				calendar.	
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR //05/25 - 05/06/25	K 0000	Preparation and execution of the plan of correction does not constitute admission or agreer of provider of the truth of the factor alleged or conclusions set from the State of Deficiencies. The plan of Correction is prepared	ment acts orth he

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 2 of 28

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155496	B. W.	ING		05/06/	2025
	PROVIDER OR SUPPLIER		-	333 W I	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID	SIMMADV	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Facility Number: 0				executed solely because it is		
	Provider Number:	155496			required by the position of Fed	deral	
	AIM Number: 100	266930			and State Law. The Plan of		
					Correction is submitted in orde	er to	
	· ·	Code survey, Valley View			respond to the allegation of		
		was found not in compliance			non-compliance cited during t		
	with Requirements	-			survey process. Please accep	t	
		, 42 CFR Subpart 483.90(a),			this plan of correction as the	£	
	· ·	re and the 2012 edition of the ction Association (NFPA) 101,			provider's credible allegation of compliance. The facility is	ונ	
		LSC), Chapter 19, Existing			respectfully requesting a desk		
		ancies and 410 IAC 16.2.			review		
	This one-story facility was determined to be of						
	Type V (111) const	ruction and was fully					
	_	00, 600, and 700 Hall Units,					
		thern portion of the facility,					
		d and do not have any					
		hem, and are not separated by					
		rest of the facility. The facility tem with smoke detection in					
		as open to the corridors, and 1					
		ery operated smoke detectors					
		of 75 rooms resident rooms.					
	_	protected by a 75 kW natural					
		facility has a capacity of 94					
	I -	d for Medicare and Medicaid.					
	At this survey the fa	acility had a census of 81.					
		idents have customary access					
	_	The facility has a detached orage of maintenance					
		ed containing storage of wheel					
	chairs and walkers which were not sprinklered.						
	Quality Review completed on 05/12/25						
K 0211	11 NFPA 101						
SS=E Bldg. 01	Means of Egress	- General					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VTD921 Facility ID: 000523

If continuation sheet Page 3 of 28

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		î ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/06/2025			
		PROVIDER OR SUPPLIEF		333	3 W I	NDDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
	TAG		R LSC IDENTIFYING INFORMATION	TAC	G	DEFICIENCY)		DATE
			on and interview, the facility f over 9 means of egress was	K 0211		No residents were harmed by cited deficiency.	this	07/09/2025
			ained free of all obstructions			What corrective action(s) will I	эе	
		-	full instant use in the case of			accomplished for those reside		
		_	ency. This deficient practice	found to have been affect			-	
		needing to exit the	4 residents, staff and visitors if			deficient practice: The signs for		
		needing to exit the	racinty.			parking were replaced. Staff v educated on appropriate parki		
		Findings include:				spots and to not park in the fir	_	
						lane.	_	
		Based on observations and interview during a tour of the facility with the Maintenance Director				How other residents having th	е	
						potential to be affected by the		
			at 3:05 p.m., the exit discharge			same deficient practice will be	<b>!</b>	
		near RR#414, marked a facility exit, had an area at				identified and what corrective		
		the end of the sidewalk marked with lines and			action(s) will be taken: All			
			ed "No Parking" but was o cars where the sidewalk	residents have the potential to be				
		meets the parking le		affected. These updates apply all residents.			/ 10	
		meets the parking is	ot.			What measures will be put into	0	
		This finding was ac	knowledged by the ED and			place or what systemic chang		
		_	liscovery and again at the exit			will be made to ensure that the		
		conference on 05/0	6/25 with the ED, MD and			deficient practice does not rec	ur:	
		Corporate Represer	ntative all present.			Maintenance will complete rou		
		24.404.				daily x2 weeks, three times pe		
		3.1-19(b)				week for 2 weeks, and once p		
						week for three months to ensuthere is no obstruction. Any	ıre	
						issues will be addressed		
						immediately.		
						How the corrective action(s) w	/ill be	
						monitored to ensure the defici	ent	
						practice will not recur, i.e., wh		
						quality assurance program wil		
						put into place: A summary of t		
						audits will be presented to the	!	
						Quality Assurance committee monthly by ED/designee for 6		
						months. Thereafter, if determi		
						by the Quality Assurance	iicu	
						committee, auditing and		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPL	
		155496	B. W	ING		05/06	/2025
NAME OF A	DROLUBER OR GURRI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		333 W	MISHAWAKA RD		
VALLEY	VIEW HEALTHCA	RE CENTER		ELKHART, IN 46517			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					monitoring will be done quarte	•	
					and present quarterly at the Q	Α	
					meeting.		
K 0222	NFPA 101						
SS=F	Egress Doors						
Bldg. 01	Egress Doors						
Diag. 01	1 Based on observ	ration and interview, the facility	K 0	າາາ	/b>		07/09/2025
		e means of egress for the front	I K U	<i>LLL</i>	What corrective action(s) will be	ne	01/09/2023
		yard gate was readily			accomplished for those reside		
		lents without a clinical			found to have been affected b		
		specialized security measures.			deficient practice: The code fo	•	
		uired means of egress shall not			front door was posted above t		
	_	latch or lock that requires the			code box. Safe Care to repair		
	use of a tool or key	from the egress side unless			gate. Quote obtained. The sig		
	otherwise permitted	d by LSC 19.2.2.2.4.			the 15 second egress was		
	_	gements shall be permitted in			immediately placed on the		
		9.2.2.2.5.2. This deficient			affected door.		
	^	ct all staff, residents and			How other residents having th		
	visitors when need	ing to exit the facility.			potential to be affected by the		
					same deficient practice will be		
	Findings include:				identified and what corrective		
					action(s) will be taken: All		
		ons and interviews during a			residents have the potential to		
	-	with the Maintenance Director			affected. These updates apply	to to	
		at 2:25 p.m., the (A) front exit d with a code in order to			all residents.	_	
	-	ic lock and exit the facility. And			What measures will be put into		
	_	11:35 a.m. the gate from the			place or what systemic change will be made to ensure that the		
		ard was equipped with a			deficient practice does not rec		
		ch is designed to release the			The Maintenance Department		
	~	n. When tested, the button			changes the magnetic lock co		
	_	e magnetic hold and open the			and will ensure that code is	u o	
		ed that he was aware of the			present on all of the keypads.	The	
	issue and it would				Maintenance Director will be		
					re-educated on Exit Access		
	This finding was a	cknowledged by the ED and			Codes, lock release, and egre	ss	
	MD at the time of	discovery and again at the exit			door signage by the Executive		
	conference on 05/0	06/25 with the ED, MD and			Director/designee.		
	Corporate Represen	ntative all present.			How the corrective action(s) w	ill be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921 Facility ID: 000523

If continuation sheet Page 5 of 28

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155496	B. W	ING		05/06	/2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			MISHAWAKA RD		
\/A   <b>=</b> V	VIEW HEALTHCAI	DE CENTED			RT, IN 46517		
VALLET	VIEW HEALTHCA	RE CENTER		ELKHA	K1, IN 40517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					monitored to ensure the defici	ent	
	2. Based on observ	ation and interview, the facility			practice will not recur, i.e., wh	at	
	failed to ensure 1 o	of 1 delayed egress locking			quality assurance program wil	ll be	
	arrangements in the	e kitchen was installed in			put into place: An audit tool w	ill be	
	accordance with LS	SC 7.2.1.6.1(3) which states an			utilized weekly x 4 and month	ly	
	irreversible process	s shall release the lock in the			thereafter, to monitor complian	nce	
	direction of egress	within 15 seconds, or 30			with exit codes and the gate la		
	seconds where app	roved by the authority having			Audits will be reviewed in Qua		
	jurisdiction, upon a	application of a force to the			Assurance Meeting monthly for	•	
	release device requ	ired in 7.2.1.5.10 under all of			months or until 100% complia		
	the following cond	itions:			is achieved. The QA Committee	ee	
	(a) The force shall	not be required to exceed 15 lbf			will identify any trends or patte	erns	
	(67 N).				and make recommendations t	:0	
	(b) The force shall not be required to be				revise the plan of correction a	S	
	continuously applie	ed for more than 3 seconds.			indicated.		
	(c) The initiation of	f the release process shall					
	activate an audible	signal in the vicinity of the					
	door opening.						
	(d) Once the lock h	as been released by the					
	application of force	e to the releasing device,					
	relocking shall be b	by manual means only. This					
	deficient practice c	ould affect 6 staff.					
	Findings include:						
	Based on observati	ons and interview during a					
	tour of the facility	with the Maintenance Director					
		at 3:40 p.m., the kitchen exit near					
		was equipped with a 15 second					
		nen the exit doors were tested					
		cess to release the lock was not					
	_	interview at the time of					
	observation, the Su	rveyor and MD tried 3 times to					
		egress. The MD stated the					
	delayed egress is not working and will need to be						
	repaired.						
	•						
	This finding was a	cknowledged by the ED and					
		discovery and again at the exit					
		06/25 with the ED, MD and					

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155496		i '	UILDING	nstruction 01	(X3) DATE COMPL <b>05/06</b> /	ETED	
	ROVIDER OR SUPPLIEF			333 W N	DDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Itative all present.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3. Based on observation failed to ensure the over 5 delayed egree for all residents, state (3) (4) states a read letters not less than than 1/8 in. (3.2mm contrasting backgroshall be located on release device in the UNTIL ALARM SOPENED IN 15 SET This deficient pract Findings include:  Based on observation of the facility of (MD) on 05/05/25 a located near RR#41 egress magnetic located signage indicating the seconds by pushing interview at the time Maintenance Direct equipped with delay lacked proper signal. This finding was act MD at the time of delay the seconds of the signage indicating the seconds.	ation and interview, the facility means of egress through 1 of ess locks was readily accessible ff, and visitors. LSC 7.2.1.6.1. illy visible, durable sign in 1 in. (25mm) high and not less in in stroke width on a bund that reads as follows the door leaf adjacent to the edirection of egress: "PUSH OUNDS. DOOR CAN BE CONDS". ice could affect 15 residents.  The maintenance Director at 3:17 p.m., the exit door 4 was provided with delayed eks but lacked the proper the doors can be opened in 15 in the door. Based on the door. Based on the of observation, the tor acknowledged the door was yed egress magnetic locks and ge.  Sknowledged by the ED and discovery and again at the exit 6/25 with the ED, MD and					
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 7 of 28

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIER			333 W I	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	failed to ensure 1 of sets were arranged to latch. LSC section assemblies in horizon or automatic-closing Standard for Fire D. Protectives, section doors shall swing eaction equipped with a clost to close and latch eactificient could affes smoke compartmen. Findings include:  Based on observation of the facility of t	ons and interview during a with the Maintenance Director at 11:03 a.m., the 1½ hour rated R#509 was in use as a sa as a smoke barrier. When ed to latch into the frame. at the time of observation, the or stated the door set was not me.  knowledged by the ED and iscovery and again at the exit 5/25 with the ED, MD and	K 0	226	What corrective action(s) will accomplished for those reside found to have been affected by deficient practice: The doors repaired to ensure proper late and closure.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put interplace or what systemic change will be made to ensure that the deficient practice does not react the Maintenance Departmen audit all self-closing doors dat two weeks, weekly for two we and monthly for three months ensure proper functioning. How the corrective action(s) weeks, weekly for two weeks, and monthly for three months ensure proper functioning. How the corrective action(s) weeks, and monthly for three months. Audits will be reviewed, and worthly for the months or until 100% compliance is achieved QA Committee will identify and trends or patterns and make recommendations to revise the plan of correction as indicated.	ents by the were ching ne chin	07/09/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VTD921 Facility ID: 000523

If continuation sheet Page 8 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIE		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD ART, IN 46517	
(X4) ID PREFIX TAG K 0271	(EACH DEFICIENT REGULATORY OF NFPA 101	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
SS=E Bldg. 01	failed to ensure 1 or nominally level was obstructions. LSC in elevation of wall 1/4 inches. This deresidents using the Findings include:  Based on observation tour of the facility (MD) on 05/05/25 exit discharge was braking sidewalk in presented a trip haz time of observation acknowledged that repair to have a conthat was free of trip way.  This finding was as MD at the time of observation of the time of observation acknowledged that repair to have a conthat was free of trip way.	on and interview, the facility of 9 exit discharges had a alking surface and free of 7.1.6.2 states abrupt changes king surfaces shall not exceed ficient practice could affect 25 memory care exit.  ons and interview during a with the Maintenance Director at 3:05 p.m., the memory care eroded, loose gravel, holes and hade the discharge uneven and eard. Based on interview at the analysis and the Maintenance Director the walkway was in need of mplete level walking surface of hazards leading to the public eknowledged by the ED and discovery and again at the exit 6/25 with the ED, MD and	K 0271	/b> What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: A quote has been obtained for correction of sidewalk for the exit discharge How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recomplished the potential to affected. These updates apply all residents.  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recomplished the practice does not recomplished to ensure pathways clear and free of trip hazards of for two weeks, weekly for two weeks, and monthly for three months Any issues will be addressed immediately. How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place: An audit tool will daily for two weeks, weekly for weeks, and monthly for three months. Audits will be reviewed Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.	this by the set of the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921 Facility ID: 000523

If continuation sheet

Page 9 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155496		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/06/2025	
	ROVIDER OR SUPPLIER		STREET 333 W ELKHA		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0281	NFPA 101			QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	÷
SS=F Bldg. 01	Illumination of Mea	· ·			
	determined that the exterior emergency Section 7.9.1.1 required facilities for means the exit access and operative could affect including staff, visit were required to evariate tour of the facility of (MD) on 05/05/25 apath leading to the properties of the propert	knowledged by the ED and iscovery and again at the exit 6/25 with the ED, MD and	K 0281	/b> What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: The signs wimmediately repaired during the survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recompliately and the same daily for two weeks weekly for two weeks, and monthly for three months. Any issues will be addressed immediately. How the corrective action(s) will monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will put into place: An audit tool will daily for two weeks, weekly for	be to be to be see to be see to be t

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 10 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  05/06/2025	
VALLEY	PROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD ART, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				weeks, and monthly for three months. Audits will be reviewed Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	. The y e
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage				
	failed to install exit accordance with LS other than main extrand clearly are iden marked by an approfrom any direction of states horizontal convithin an exit enclor approved exit or direction of the This deficient practices dents.  Findings include:  Based on observation tour of the facility with t	on and interview; the facility signage in 1 of over 8 exits in C 7.10. LSC 7.10.1.2.1 exits, erior exit doors that obviously tifiable as exits, shall be wed sign that is readily visible of exit access. LSC 7.10.1.2.2 mponents of the egress path sure shall be marked by ectional exit signs where the egress path is not obvious. ice could affect up to 23 exit the Maintenance Director at 3:55 p.m., the dining room exit ignage once exiting the facility. It exit discharge had 2 options or left). There was no present to indicate which path in to a parking lot or the public ed path would return to the real building entrance door. The or agreed that the exit needed	K 0293	What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice: The signs with immediately repaired during the survey process.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put interplace or what systemic chang will be made to ensure that the deficient practice does not recommend the made to ensure pathways illuminated daily for two weeks weekly for two weeks, and monthly for three months. Any issues will be addressed immediately.  How the corrective action(s) will accomplished the made to ensure pathways illuminated daily for two weeks weekly for two weeks, and monthly for three months. Any issues will be addressed immediately.	ents y the were ne e  b b b t t t t t t t t t t t t t t t

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921 Facility ID: 000523

If continuation sheet

Page 11 of 28

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		r í	A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED 05/06/2025	
	ROVIDER OR SUPPLIER		333	ET ADDRESS, CITY, STATE, ZIP COD W MISHAWAKA RD HART, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	MD at the time of d	knowledged by the ED and iscovery and again at the exit 6/25 with the ED, MD and		monitored to ensure the de practice will not recur, i.e., quality assurance program put into place: An audit too daily for two weeks, weekly weeks, and monthly for thr months. Audits will be revie Quality Assurance Meeting monthly for 6 months or un 100% compliance is achiev QA Committee will identify trends or patterns and make recommendations to revise plan of correction as indicated.	what will be I will be r for two ee ewed in I til red. The any se e the	
	NFPA 101 Hazardous Areas - Enclosure					
	failed to ensure the hazardous rooms we self-closing device automatically close. This deficient practifive smoke compart. Findings include:  Based on observation tour of the facility we (MD) on 05/05/25, following hazardous feet, and containing meet the requirement hazardous area:  a) at 3 p.m. on 05/0. Hall did not self-close at 3:10 p.m. on 0 the 400 Hall, was last	which would cause the door to and latch into the door frame. ice could affect 52 residents in ments.  ons and interview during a with the Maintenance Director the corridor doors to the sareas, greater than 50 square combustible material, did not not for protection of a	K 0321	/b> What corrective action(s) waccomplished for those restound to have been affected deficient practice: The ide doors have automatic closs installed and all door latched doors replaced and/or repatire wall will be constructed between the hallway and the South Unit. How other residents having potential to be affected by same deficient practice will identified and what correct action(s) will be taken: All residents have the potential affected. These updates all residents. What measures will be put place or what systemic chawill be made to ensure tha	sidents d by the ntified ers es and aired. A he g the the l be eve al to be opply to into anges	07/09/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 12 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIER VIEW HEALTHCAF		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD ART, IN 46517	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG	self-close and latch c) at 3:11 p.m. on 0	5/05/25 the TV room on the 400	TAG	deficient practice does not real	e will
	latch.	s station did not self-close and 5/05/25 the chemical storage		audit self-closing doors week ensure they are functioning appropriately. Maintenance	ly to
	latch and was obstr	undry area did not close and ucted with a vacuum cleaner enting the door from closing.		Director and/or designee will document the audit in TELS. issues will be addressed	Any
	and trash can, preventing the door from closing. e) at 4:25 p.m. on 05/05/25 the storage room on the 200 Hall near the janitor's closet failed to self-close			immediately.  How the corrective action(s) with the monitored to ensure the deficiency.	<b>I</b>
	and latch. f) at 4:26 on 05/05/25 the Salon which contained lots and lots of combustible storage failed to			practice will not recur, i.e., who quality assurance program with	nat
	the 100 Hall, equip	5/05/25 the clean linen room on ped with a self-closing device		put into place: Audits will be reviewed in Quality Assuranc Meeting monthly for 6 months	
		and latch. 5/05/25 the Copy Machine and lots of combustible paper		until 100% compliance is achieved. The QA Committee identify any trends or patterns	
	i) at 4:36 p.m. on 0:	or failed to self-close and latch.  5/05/25 the Administrators as of combustible material		make recommendations to re the plan of correction as indic	
	and latch into the de	oxes, the door did not self-close oor frame. of the facility which had been			
	separated by a 2 ho	was not occupied, was not ur fire wall, marked as a facility ied area of the building had			
	several rooms, inclumost of which were	nding former resident rooms, being used as storage and			
	such as crates, boxe of the rooms had th	mbustible storage product is furniture and supplies. Some e doors removed, some had			
	in the doors. Many	rdware which resulted in holes of the rooms had the s removed and were not easily			
	did not have self-cl	doors no longer latch and most osing hardware. The following at throughout the tour of the			
		n 10:45 a.m. and 11:55 a.m. on			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 13 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  05/06/2025	
	ROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD .RT, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	Corporate Represent hazardous areas with mentioned condition Rooms # 505, 507, Management Office Unidentified room on near Room # 702, 7 Closet near 701, Sh. Janitors Closet, 601 Central Supply. The MD and Corporate a lot of work would storage which had a This finding was ac MD at the time of diconference on 05/00 Corporate Represent 3.1-19(b)  NFPA 101  Cooking Facilities  Based on observation failed to provide an returning cooking a when the kitchen how was designed and in extinguishing system Ventilation Control Commercial Cooking Edition Section 12 requiring protection or rearranged without fire-extinguishing systems or servicing agent, a the design of the fire-	509, Central Supply, Case c, Activities Directors Office, containing old covid boxes 02, 704, 708, 709, 707, 705, 703, ower door, Medication Room, c, 603, 605, 606, 604, 602, 502, rate Representative stated that be needed due to years of ccumulated in the area. knowledged by the ED and iscovery and again at the exit 5/25 with the ED, MD and	K 0324	/b> What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice: Wheel cho have been ordered to place of floor for equipment positioning. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.	ents by the locks in the log. ine

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921 Facility

Facility ID: 000523

If continuation sheet

Page 14 of 28

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		lì í	UILDING	onstruction 01	(X3) DATE COMPI <b>05/06</b>	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD		
VALLEY	VIEW HEALTHCAI	RE CENTER			RT, IN 46517		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION  (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION evaluation where the cooking		TAG			DATE
	_	red for the purposes of			What measures will be put into place or what systemic change		
	* *	eaning, provided the			will be made to ensure that the		
		rned to approved design			deficient practice does not rec		
		oking operations, and any			Maintenance and/or designee		
	_	xtinguishing system nozzles			audit to ensure wheel chocks		
		liances are reconnected in			correctly in place weekly x6		
		e manufacturer's listed design			months.		
		.1.2.3.1 An approved method			How the corrective action(s) w	ill be	
	shall be provided th	nat will ensure that the			monitored to ensure the defici		
	appliance is returned to an approved design location. The deficient practice affected 8 residents, staff, and no residents.  FIndings include:				practice will not recur, i.e., wh	at	
					quality assurance program wil	l be	
					put into place: An audit tool wi	ll be	
					used weekly x6 months. Audit	s	
					will be reviewed in Quality		
					Assurance Meeting monthly for		
		ons and interview during a			months or until 100% complia		
	-	with the Maintenance Director			is achieved. The QA Committe		
		at 3:45 p.m., the gas wheeled six			will identify any trends or patte		
		th flat grill which was located			and make recommendations t		
	_	under the hood in the kitchen			revise the plan of correction as	S	
	_	vith an approved method that			indicated.		
		he appliance was returned to location after it had been					
		ance and cleaning. Based on					
		Maintenance Director, the					
		are an approved method should					
	-	are that the appliance was					
		oved design location after					
	maintenance or clea	•					
		8					
	This finding was ac	cknowledged by the ED and					
		discovery and again at the exit					
	conference on 05/0	6/25 with the ED, MD and					
	Corporate Represer	ntative all present.					
	3.1-19(b)						
K 0346	NFPA 101						
SS=C	Fire Alarm Syster	n - Out of Service					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921 Facility ID: 000523

If continuation sheet Page 15 of 28

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		, ,	JILDING	onstruction 01	(X3) DATE COMPL 05/06/	ETED	
	ROVIDER OR SUPPLIER			333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 01	failed to provide a comprocedures to be followed a comprocedures to be followed alarm system has to four hours or more accordance with LS deficient practice afformation of the comprocedure of the comprocedure of the comprocedure of the facility administration of the comprocedure of the facility administration of the comprocedure of the facility administration of the comprocedure of t	eview and interview with the (ED) and Maintenance Director at 11:50 a.m., the fire watch plan rent contact information for trator and maintenance  knowledged by the ED and liscovery and again at the exit 6/25 with the ED, MD and	KO	346	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: The contact information was updated immediately during the survey process.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not receive facility listing identificat when reviewing Emergency Preparedness Program plan's every 12 months in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director review the Emergency Preparedness Program at least annually.  How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place: Annual review of the facility listing in the Emergency Preparedness	ents  y the  t  e  be  t  c  c  c  c  c  c  c  c  c  c  c  c	07/09/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921 Facility ID: 000523

If continuation sheet Page 16 of 28

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155496 B. WING 05/06/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 333 W MISHAWAKA RD VALLEY VIEW HEALTHCARE CENTER ELKHART, IN 46517 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Program was added to the QAPI calendar. K 0351 **NFPA 101** SS=E Sprinkler System - Installation Bldg. 01 Based on observation and interview, the facility K 0351 /b> 07/09/2025 failed to maintain the ceiling construction in in What corrective action(s) will be accordance with NFPA 13, Standard for the accomplished for those residents Installation of Sprinkler Systems. NFPA 13, 2010 found to have been affected by the edition, Section 6.2.7.1 states plates, escutcheons, deficient practice: A quote has or other devices used to cover the annular space been obtained for correction of around a sprinkler shall be metallic, or shall be sprinklers in the South Wing. Safe listed for use around a sprinkler. This deficient Care to correct deficiencies. practice could affect staff and up to 5 staff. How other residents having the potential to be affected by the Findings include: same deficient practice will be identified and what corrective Based on observations and interview during a action(s) will be taken: All tour of the facility with the Maintenance Director residents have the potential to be (MD) on 05/06/25 at 11:00 a.m., 2 of 2 Sprinkler affected. These updates apply to Heads in RR#507 were sticking down from the all residents. ceiling and were bent sideways. This resulted in What measures will be put into missing escutcheons which did not completely place or what systemic changes cover the hole around the sprinklers. Additionally, will be made to ensure that the throughout the South Wing sprinkler head issues deficient practice does not recur: such as described earlier were observed. The MD Maintenance and/or designee will and Corporate Support Representative stated that audit exits to ensure sprinklers are they would ensure all the sprinkler heads are appropriately positioned and corrected. annular space is appropriately covered daily for two weeks, This finding was acknowledged by the ED and weekly for two weeks, and MD at the time of discovery and again at the exit monthly for three months. Any issues will be addressed conference on 05/06/25 with the ED, MD and Corporate Representative all present. immediately. How the corrective action(s) will be 3.1-19(b) monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

put into place: An audit tool will be

Page 17 of 28

<u> </u>		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	·			COMPL	ETED
		155496	B. W	ING	_	05/06/	/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 333 W MISHAWAKA RD ELKHART, IN 46517			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0353 SS=E Bldg. 01	Based on observation failed to maintain the over 6 corridors and hot air and gases are	- Maintenance and Testing on and interview, the facility ne ceiling construction of 3 of d rooms. The ceiling tiles trap ound the sprinkler and cause	K 0	353	daily for two weeks, weekly fo weeks, and monthly for three months. Audits will be reviewed Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated /b>  /b> What corrective action(s) will be accomplished for those reside found to have been affected by	ed in  . The y e i.	07/09/2025
	the sprinkler to open NFPA 13, 2010 edit between the sprinkle above shall be select sprinkler and the type deficient practice afformation of the facility with the selection of the select	rate at a specified temperature.  tion, 8.5.4.11 states the distance er deflector and the ceiling ted based on the type of pe of construction. This fects 24 residents.  ons and interview during a with the Maintenance Director suspended ceiling tile were lled correctly in the following  05/05/25 in the "IT" room.  05/06/25 In the corridor near missing.  05/06/25 in the corridor near			deficient practice: The tiles we fixed and/or replaced as necessary. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recommend to make the place and the place deaily for two weeks, we for two weeks, and monthly for three months Any issues will the addressed immediately. How the corrective action(s) we	e be be or to be sur: will nekly	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 18 of 28

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155496			A. BUILDING B. WING	01	COMPLETED 05/06/2025
	PROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD .RT, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0354 SS=C	conference on 05/06 Corporate Represen 3.1-19(b)			monitored to ensure the deficie practice will not recur, i.e., what quality assurance program will put into place: An audit tool with daily for two weeks, weekly for weeks, and monthly for three months. Audits will be reviewed Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	at I be ill be r two ed in . The
Bldg. 01	Based on record rev failed to provide 1 of the event the automate placed out-of-service 24-hour period in acceptation of the Standard for the Maintenance of Warsystems. NFPA 25-procedures that the follow. A.15.5.2 (4) consist of trained perpatrol the affected a extinguishers and that the fire department acconsider. During the should not only be building such as egrare available and fur	iew and interview, the facility of 1 correct written policies in atic sprinkler system has to be e for 10 hours or more in a ecordance with LSC, Section quires sprinkler impairment with NFPA 25, 2011 Edition, Inspection, Testing and ter-Based Fire Protection of 15.5.2 requires nine impairment coordinator shall (b) states a fire watch should resonnel who continuously rea. Ready access to fire e ability to promptly notify are important items to e patrol of the area, the person cooking for fire, but making re protection features of the ess routes and alarm systems metioning properly. This could affect all occupants in the	K 0354	/b> What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: The contact information was updated immediately during the survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconcert to the potential to deficient practice does not reconcert.	ents y the e  b b b t  t  t  t  t  t  t  t  t  t  t

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 19 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  05/06/2025	
	PROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD ART, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0361	Executive Director (MD) on 05/05/25 a failed to include cur the facility administ director.  This finding was ac MD at the time of d	view and interview with the (ED) and Maintenance Director t 11:50 a.m., the fire watch plan rent contact information for rator and maintenance knowledged by the ED and iscovery and again at the exit 5/25 with the ED, MD and tative all present.		review facility listing identificat when reviewing Emergency Preparedness Program plan's every 12 months in QAPI. The QAPI calendar was updated for the Executive Director/Maintenance Director review the Emergency Preparedness Program at least annually.  How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place: Annual review of the facility listing in the Emergency Preparedness Program was added to the QAP calendar.	e to st vill be ent at I be of
SS=E Bldg. 01	Based on observation failed to ensure 3 of quantity of combust corridor was not used 19.3.6.1(7) states the sleeping rooms, treat areas shall be open in area, provided: (at which the space open compartment are presupervised automatic accordance with 19 protected by an autospace does not to observation.	Open to Corridor  on and interview, the facility 3 alcoves with a large ible material open to the ed as hazardous storage. LSC at spaces other than patient attent rooms, and hazardous to the corridor and unlimited b) The space and corridors cans onto in the same smoke beteted by an electrically c smoke detection system in 3.4, and (b) Each space is omatic sprinklers, and (c) The estruct access to required t practice could affect staff in	K 0361	/b> What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice: The identificitems were moved to an appropriate storage location. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents. What measures will be put into place or what systemic change.	nts y the ed e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 20 of 28

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/06/2025
	PROVIDER OR SUPPLIER		333 W	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD .RT, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE
	tour of the facility we (MD) on 05/06/25 at Common Area, open hazardous storage of that were flame retareombustible materia (2) at 11:22 a.m. the corridor, contained similar to the aforem (3) at 11:40 in the Starea, open to the coadditional mattresses. Based on interview Maintenance Direct would need to be mutually to the finding was ac MD at the time of deciding the start of the factor of t	e Lobby Area, open to the at least 15 more mattresses mentioned mattresses. Second South Wing Common bridor, at least a dozen es were being stored. at the time of observation, the cor, stated the mattresses loved.  knowledged by the ED and discovery and again at the exit 6/25 with the ED, MD and		will be made to ensure that the deficient practice does not recommended to the appropriate storage locations. All items has been moved to appropriate locations. Maintenance and/ordesignee will audit areas to eno items are being stored inappropriately in the identificareas daily for two weeks, we for two weeks, and monthly for three months Any issues will addressed immediately. How the corrective action(s) who monitored to ensure the deficing practice will not recur, i.e., who quality assurance program will put into place: An audit tool who used daily for two weeks, we for two weeks, and monthly for three months. Audits will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rethe plan of correction as indicated.	cur: e ave r nsure d eekly or be vill be eient eat ll be fill be ekly or e s or e will s and vise
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors				
	failed to ensure all of with a means suitable had no impediment	on and interview, the facility corridor doors were provided alle for keeping the door closed, to closing, latching and would of smoke. This deficient to 2 staff.	K 0363	/b> What corrective action(s) will accomplished for those reside found to have been affected the deficient practice: All staff immediately reeducated on the use of items to prop open documents.	ents by the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 21 of 28

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	of Correction identification number 155496	A. BUILDING  B. WING	01	COMPLETED 05/06/2025
	PROVIDER OR SUPPLIER VIEW HEALTHCARE CENTER	333 W I	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0741	Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 05/05/25 at 2:45 p.m., the corridor door to the physicians prep room was propped open with a door stop wedge. Based on interview at the time of observation, the MD acknowledged the aforementioned corridor door would not close unless the wedge was first removed. A physician was present in the room and stated that the tiny room gets warm and that they prop the door open to get air.  This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present.  3.1-19(b)		and door stop removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not rec Staff have been reeducated or propping doors open. Mainten and/or designee will audit area ensure no self closing doors a being propped open daily for tweeks, weekly for two weeks, monthly for three months Any issues will be addressed immediately. How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will put into place: An audit tool with used daily for two weeks, weekly for two weeks, weekly for two weeks, weekly for two weeks, weekly for the deficient practice will not recur, i.e., what are to be a surface of the place of the QA Committee in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to reverthe plan of correction as indicated.	be to  ces e ur: n not ance as to re wo and  ill be ent at be ll be kly r  cor will and rise
SS=E	Smoking Regulations			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 22 of 28

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION  G  01	(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIER VIEW HEALTHCAF		333	EET ADDRESS, CITY, STATE, ZIP COD B W MISHAWAKA RD KHART, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
Bldg. 01	interview, the facilinon-smoking policic could affect residen  Findings include:  Based on observation tour of the facility words (MD) on 05/05/25 aproperty was evider vaping in resident review at 12:07 p.m. stated "for the purposand vaporizers will cigarette."  This finding was ac MD at the time of designed in the state of the country of the purposand vaporizers will cigarette."	on, records review, and try failed to enforce 1 of 1 es. This deficient practice ts and staff in the 200 Hall.  ons and interview during a with the Maintenance Director at 4:22 p.m., vaping in the et as a resident was observed from #208. Based on records and the facility's smoking policy ose of this policy, e-cigarettes be treated as a traditional exhausted with the ED and exist is size with the ED, MD and tative all present.	K 0741	What corrective action(s) accomplished for those refound to have been affected deficient practice: The reswas immediately re-educate regarding the smoking polall smoking items removed the room. Resident was is 30 day discharge notice do non compliance with smoking policy.  How other residents having potential to be affected by same deficient practice wite identified and what correct action(s) will be taken: All residents have the potential affected. These updates a all residents.  What measures will be purplace or what systemic chaill be made to ensure the deficient practice does not angel rounds are complete weekly which includes observations of smoking rounds are complete weekly which includes observations of smoking rounds are they are following smoking policy.  How the corrective action (monitored to ensure the depractice will not recur, i.e., quality assurance program put into place: Angel round continue to be completed and ongoing to ensure compliance. Audits will be reviewed in Quality Assurance program for the program of the program	sidents ed by the sident ited icy and d from sued a ue to king g the the II be tive al to be pply to t into anges at the t recur: ely esidents ag the s) will be eficient what a will be ds will weekly

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 23 of 28

IDENTIFICATION NUMBER  155496	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/06/2025
CARE CENTER	333 W ELKHA	MISHAWAKA RD	
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rev the plan of correction as indicated	and ise
ecorations			
1 of over 50 corridor doors on that did not exceed 30 percent C 18.7.5.6 states combustible 1 be prohibited in any health care assone of the following criteria is me-retardant or are treated with tardant coating that is listed and ication to the material to which it is ons meet the requirements of adard Methods of Fire Tests for ion of Textiles and Films. Ons exhibit a heat release rate not a two when tested in accordance with adard Method of Fire Test for Packages, using the 20 kW ions, such as photographs, ther art, are attached directly to g, and non-fire-rated doors in the following: on non-fire-rated doors do not e operation or any required loor and do not exceed the area 3.7.5.6(b), (c), or (d). do not exceed 20 percent of the d door areas inside any room or	K 0753	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: The decorations and candles were immediately removed.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconstant and residents were reeducated on the regulation the decorations may not exceed 30 of the door and candles not be allowed within the facility.  Guardian angel rounds will be completed weekly to ensure the any decorations do not exceed allowed amount and no candle are present.  How the corrective action(s) will be	the to be to be to be ur:  nat 0% ing at the es
	IDENTIFICATION NUMBER	DENTIFICATION NUMBER 155496  LIER  CARE CENTER  RY STATEMENT OF DEFICIENCIE DENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION  DECORATION  REPORT OF THE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION  REPORT OF THE PREFIX TAG  RY STATEMENT OF DEFICIENCIE DECENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION  K 0753  K 0	DENTIFICATION NUMBER 155496  LIER  CARE CENTER  EXPOSITE STATEMENT OF DEFICIENCIE EXENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION  DECORAGE CENTER  EXPOSITE STATEMENT OF DEFICIENCIE EXENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION  DECORAGE REFERENCED TO THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION  DECORAGE REFERENCED TO THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION  DECORAGE REFERENCED TO THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION  DECORAGE REFERENCED TO THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE PRECEDED BY FULL YOU AND THE APPROPRIATION OF COMPLETENCY MUST BE ALL HARD TO THE APPROPRIATION OF COMPLETENCY AND THE APPROPRIATION OF THE APPROPRIATION

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 24 of 28

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496	r í	UILDING	nstruction 01	(X3) DATE COMPL 05/06/	ETED
	PROVIDER OR SUPPLIER			333 W N	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(c) Decorations do a wall, ceiling, and do space of a smoke conthroughout by an apprinkler system in (d) Decorations do a wall, ceiling, and do sleeping rooms have four persons, in a stransform persons, in a stransform persons, in a stransform protected throughout automatic sprinkler Section 9.7.  This deficient praction of the facility of the facility of the facility of (MD) on 05/05/25 and door was covered of Christmas decoration was not the with a combustible decoration was not the finding was act MD at the time of doconference on 05/06 Corporate Representation 2. Based on observation and the time of doconference on 05/06 Corporate Representation and 19.7.5.6 prohibits of the same and the same a	accordance with Section 9.7. not exceed 30 percent of the por areas inside any room or compartment that is protected percent of the por areas inside patient ing a capacity not exceeding moke compartment that is at by an approved, supervised system in accordance with fice could affect 20 residents.  The Maintenance Director at 4:29 p.m., RR#110 corridor completely with paper and are wrapping. The Maintenance corridor door was covered decoration and stated the treated and will be removed.  Rem			practice will not recur, i.e., who quality assurance program will put into place: Audits will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to revithe plan of correction as indicated in the plan of correction	l be or will and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet

Page 25 of 28

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155496		JILDING	nstruction 01	(X3) DATE ( COMPL 05/06/	ETED
	PROVIDER OR SUPPLIER			333 W N	ADDRESS, CITY, STATE, ZIP COD MISHAWAKA RD RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	tour of the facility v (MD) on 05/06/25 a on the South Wing approximately 8 sm agreed the candles v station.  This finding was ac MD at the time of d	ons and interview during a with the Maintenance Director at 11:39 a.m., the nurse's station had a container with all candles. The MD and ED were present at the nurse's knowledged by the ED and iscovery and again at the exit 6/25 with the ED, MD and tative all present.					
K 0923 SS=E Bldg. 01	3.1-19(b)  NFPA 101  Gas Equipment - 0  Storag	Cylinder and Container					
	failed to ensure 1 of nonflammable gases cubic feet were secu entry. NFPA 99, H Edition, Section 11. shall be outdoors in enclosed interior splimited combustible gates outdoors) that unauthorized entry. affect 25 residents i storage.  Findings include:  Based on observation tour of the facility w (MD) on 05/05/25 a storage location had door. The tether for	on and interview, the facility I storage locations of s equal to or greater than 3000 ared against unauthorized ealth Care Facilities Code, 2012 3.2.1 states storage locations an enclosure or within an acce of noncombustible or c construction, with doors (or can be secured against This deficient practice could in the vicinity of the oxygen  ons and interview during a with the Maintenance Director at 3:34 p.m., the locked oxygen I a key that was left in the the key (which was not in axt to the lock making it	K 09	923	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: The key was removed from the door and plain an alternate location.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected. These updates apply all residents.  What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recomplete Maintenance and staff reeduced on appropriate key storage and usage. An audit tool will be use	nts y the as aced e be to ces e ur: ated d	07/09/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet Page 26 of 28

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
1554		155496	B. WING			05/06/2025		
			<u> </u>	CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD			
VALLEY VIEW HEALTHCARE CENTER				333 W MISHAWAKA RD				
VALLET	VIEW REALIRCAP	RECENTER		ELNHA	RT, IN 46517			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	accessible by residents in the facility when the key was in the lock or on the tether. Based on interview at the time of the observations, the MD				daily for two weeks, weekly for	r two		
				weeks, and monthly for three months to ensure the key is in the				
						the		
	stated a new locatio	n for the key would need to be		proper place				
	discussed.				How the corrective action(s) w	ill be		
					monitored to ensure the defici-	ent		
	This finding was ac	knowledged by the ED and			practice will not recur, i.e., wha	at		
	MD at the time of d	iscovery and again at the exit		quality assurance program wil		be		
	conference on 05/06	5/25 with the ED, MD and		put into place: An audit tool w		ll be		
	Corporate Represen	tative all present.		used daily for two weeks, weekly		kly		
					for two weeks, and monthly fo	r		
	3.1-19(b)				three months to ensure the ke	y is		
					in the proper place. Audits will	be		
					reviewed in Quality Assurance	) )		
					Meeting monthly for 6 months	or		
					until 100% compliance is			
					achieved. The QA Committee	will		
					identify any trends or patterns	and		
					make recommendations to rev	⁄ise		
					the plan of correction as indica	ated.		
K 0927	NFPA 101							
SS=E	Gas Equipment -	Transfilling Cylinders						
Bldg. 01								
		on and interview, the facility	K 09	927	/b>		07/09/2025	
		f 1 oxygen storage/transfer			What corrective action(s) will b			
	_	d with a sign indicating that			accomplished for those reside			
	-	rring. NFPA 99 11.5.2.3.1(3)			found to have been affected by	•		
	_	osted with signs indicating			deficient practice: Signs were			
	_	occurring and that smoking in			installed to delineate the area	as a		
		is not permitted. This deficient			no smoking area. An in use si	gn		
	practice could affec	t 25 residents.			was immediately installed to			
					indicate when the room is in u	se		
	Findings include:				or open.	ļ		
					How other residents having the			
		ons and interview during a			potential to be affected by the			
		with the Maintenance Director			same deficient practice will be	ļ		
		at 3:33 p.m., the oxygen			identified and what corrective	ļ		
		m did not have a posted sign			action(s) will be taken: All	ļ		
	making a clear disti	nction between when			residents have the potential to	be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VTD921

Facility ID: 000523

If continuation sheet Page 27 of 28

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

PRINTED: 06/04/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155496		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  05/06/2025			
NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD  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 PROVIDER PREFIX (EACH CORREC CROSS-REFEREN TAG	S PLAN OF CORRECTION TIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE			
	transferring of oxygen is occurring in this location and when it is not.  Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not.  This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference on 05/06/25 with the ED, MD and Corporate Representative all present.  3.1-19(b)	affected. The all residents. What measure place or what will be made deficient prace where weeks, week monthly for the ensure the keep place. How the corresponding to practice will requality assurately used daily for for two weeks three months in the proper reviewed in Common Meeting mon until 100% con achieved. The identify any the make recommendate with the measure put into place with the proper reviewed in Common measurements.	res will be put into t systemic changes to ensure that the ctice does not recur: and/or designee will tool daily for two dly for two weeks, and hree months to ey is in the proper ective action(s) will be ensure the deficient not recur, i.e., what ance program will be e: An audit tool will be r two weeks, weekly s, and monthly for to ensure the key is place. Audits will be Quality Assurance thly for 6 months or			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VTD921 Facility ID: 000523 If continuation sheet Page 28 of 28