STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Healthcare Center	333 W Mishawaka Rd Elkhart, IN 46517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal and mental abuse for 1 of 5 residents reviewed for abuse, (Resident B). Finding includes: During an observation in the resident's room on 2/9/22 at 11:47 A.M., Resident B was observed sitting in a wheelchair with above the knee prosthetics applied to both legs. During an interview at that time, Resident B indicated he was blind and required assistance for activities of daily living including assistance to use the restroom. The resident indicated on 1/23/22 sometime in the afternoon, he was being assisted in the bathroom, slipped and let himself down on the bathroom floor. Resident B indicated 2 aides were trying to help him get to his chair when Licensed Practical Nurse (LPN) 8 entered the room and told him to take his medications at that time. The resident indicated he told LPN 8 he would take his medications when the aides got him off the floor and into his chair, he did not want to take the medications while sitting on the floor. Resident B indicated LPN 8 became angry, yelled at him saying he had behavior issues and accused him of refusing medications. The resident indicated LPN 8 kicked everyone out of the room. Resident B indicated staff returned to the room and transferred him to bed using the mechanical lift. Resident B indicated he felt safe at the facility but worried nurses could make mistakes and he did not want LPN 8 to ever come in to his room again. During an interview on 2/10/2022 at 1:25 P.M., the Administrator indicated he was notified by phone of the incident on Sunday 1/23/22 right after the occurrence and notified the Director of Nursing (DON), to go to the facility to assess the incident. The Administrator indicated the DON did not find any concerns at that time and did not trigger an investigation until the following day after interviews. After the DON interviewed staff she realized she needed to make a report to the State Agency. The Administrator indicated LPN 8 was allowed to work the remainer of the 2:00 P.M. to 10:00 P.M. shift but her assignment was changed so she would no longer be caring for Resident B. The Administrator indicated in retrospect, LPN 8 should probably have been sent home at the time of the incident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 2/10/22 at 1:34 P.M., and indicated the Administrator notified her by phone that something was going on at the facility related to a fall or something, and requested she go to the facility to check on the incident. The DON indicated Certified Nursing Assistant (CNA) 8 notified Clinical Manager (CM) 1 that CNA 9 was with Resident B in the bathroom when his prosthetic leg broke and he was lowered to the floor. The DON indicated she interviewed Resident B and the resident reported he was fine and not hurt, he just did not want LPN 8 to take care of him anymore. The DON indicated in her interview with LPN 8, that LPN reported Resident B was having behaviors and indicated the resident refused his medications and that she was just talking to the resident. The DON indicated LPN 8 did not want to write a statement until the CNAs made their report. The DON indicated that she did not ask LPN 8 if she yelled at Resident B, or if she had been abusive in any way. The DON indicated she did not interview CNA 8 because she was upset and CM1 sent her to take a break and calm down. The DON indicated she did not interview CNA 9 because she must have been doing patient care somewhere. DON indicated she got some staff witness statements, but couldn't get them all and instructed the the unit manager, LPN 9, to finish getting statements. DON indicated she was investigating in the facility on 2/23/22 from 4:30 P.M. to 6:00 P.M. The DON indicated she did not find any concerns regarding the incident, so allowed LPN 8 to remain at work but moved her from Resident B's care to work in a different hall, 100 Hall. The following day after collecting the rest of the statements from staff, she discussed the incident with the Administrator and determined there was a problem and suspended LPN 8 at that time, pending an investigation. DON indicated LPN 8 never provided a statement, and never returned to work at the facility after the incident. The DON indicated LPN 8 should have been suspended pending an investigation at the time of the incident. During an interview on 2/10/22 at 3:29 P.M., DON indicate the incident was reported on 1/24/22 at 4:01 P.M., and that the time of the incident was incorrectly reported as 1/24/22 at 4:01 P.M The DON indicated she the incident actually occurred on 1/23/22 at 4:00 P.M. During a telephone interview with CNA 8, on 2/14/22 at 2:21 P.M., she indicated she was called to Resident B's room because he had fallen in the bathroom when his prosthetic leg broke, and CNA 9 needed help getting the resident up off the floor. CNA 8 indicated while she and other aides were in the room, LPN 8 indicated Resident B's fall was behavioral and he fell on purpose. CNA 8 further indicated that LPN 8 yelled at the resident asking if he wanted his pills or not. The resident told her he wanted them but not while he was still on the floor. CNA 8 indicated LPN 8 continued to tell the resident it was his fault that he fell and that it was a behavior. CNA 8 indicated LPN 8 screamed and said she doesn't respond to someone yelling at her and told every one to leave the resident alone while he was still on the floor. CNA 8 indicated she returned to her unit and called her unit manager, CM1 to report the incident and for guidance. On 2/17/22 at 10:44 A.M., CM1 indicated she received a call from CNA 8 who said LPN 8 was yelling at Resident B after he fell in the bathroom and that LPN 8 was trying to force him to take his meds while he was still on the ground. CM 1 indicated she was not at work that day, so immediately reported the incident to the Administrator by phone. CM 1 indicated the DON went to the facility to investigate, but allowed LPN 8 to continue working though moved her from Resident B's care. CM 1 indicated LPN 8 should have been removed from the facility pending an investigation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation file was provided by the DON on 2/17/22 at 2:00 P.M., and reviewed at that time. The staffing sheet in the file indicated LPN 8 worked on 1/23/22 from 2:00 P.M. to 10:00 P.M. and again from 10:00 P.M. to 6:30 A.M. An Incident Report dated 1/24/22 at 4:01 P.M., indicated Resident B's roommate's friend reported to the DON today that she had concerns with the interaction of the staff person and Resident B. The roommate's friend reported that the nurse was rude and antagonistic towards the resident. Immediate action taken; on 1/24/22 Nurse suspended. Interviews conducted and investigation initiated. Head to toe assessment completed on resident. The clinical record for Resident B was provided by the DON on 2/10/22 at 10:00 A.M. and reviewed at that time. The most recent comprehensive Minimum Data Set (MDS), was a Quarterly assessment dated [DATE]. The MDS indicated Resident B was cognitively intact, had adequate hearing and speech, was able to understand others, while making himself understood, had no behaviors, required extensive assistance with most activities of daily living. Resident B required assistance for transfers and balance. Diagnoses included, but were not limited to, blindness and below the knee amputations to both legs. Resident 8 utilized prosthetics to both legs. Review of a Progress Note dated 1/24/22 at 4:49 P.M., and signed by the DON, indicated Resident's roommate's fiance was in to visit and asked her about fall and incident that occurred on 1/23/21 [1/23/22]. She voiced concerns about the unprofessionalism of LPN 8. She found her to be rude and antagonistic. On 2/8/22 at 11:20 A.M., the DON provided a policy titled, Policies and Standard Procedures Subject: INDIANA Abuse & Neglect & Misappropriation of Property, dated 9/1/17 and most recently revised on 10/27/2021. The policy indicated, .Abuse: In Indiana, the willful infliction of .intimidation .with resulting . mental anguish .Willful: In Indiana, the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm .Mental Abuse In Indiana, verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering; this may include staff to resident .if it appears to be willfully directed towards a specific resident. Examples: humiliation, harassment, threats of punishment or deprivation . This Federal tag relates to complaint IN00371647. 3.1-27(a)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based on interview, and record review, the facility failed to ensure their abuse policy was implemented when the facility failed to immediately suspend a staff member following allegations of abuse for 1 of 5 residents reviewed for abuse prevention (Resident B). This deficient practice had the potential to affect all residents who resided in 13 resident rooms on the 100 Hall, all residents who resided in 12 rooms on the 200 Hall, and all residents who resided in 13 rooms on the 400 Hall. Finding includes: During an interview on 2/9/22 at 11:47 A.M., Resident B indicated he was blind and required assistance for activities of daily living including assistance to use the restroom. The resident indicated on 1/23/22, sometime in the afternoon, he was being assisted in the bathroom, slipped and let himself down on the bathroom floor. Resident B indicated 2 aides were trying to help him get to his chair when Licensed Practical Nurse (LPN) 8 entered the room and told him to take his medications at that time. The resident indicated he told LPN 8 he would take his medications when the aides got him off the floor and into his chair, he did not want to take the medications while sitting on the floor. Resident B indicated LPN 8 became angry, yelled at him saying he had behavior issues and accused him of refusing medications. The resident indicated LPN 8 kicked everyone out of the room. Resident B indicated staff returned to the room and transferred him to bed using the mechanical lift. Resident B indicated he felt safe at the facility but worried nurses could make mistakes and he did not want LPN 8 to ever come in to his room again. During an interview on 2/10/2022 at 1:25 P.M., the Administrator indicated he was notified by phone of the incident on Sunday, 1/23/22 right after the occurrence and notified the Director of Nursing (DON), to go to the facility to assess the incident. The Administrator indicated the DON did not find any concerns at that time and did not trigger an investigation until the following day after interviews. After the DON interviewed staff she realized she needed to make a report to the State Agency. The Administrator indicated LPN 8 was allowed to work the remained of the 2:00 P.M. to 10:00 P.M. shift but her assignment was changed so she would no longer be caring for Resident B. The Administrator indicated in retrospect, LPN 8 should probably have been sent home at the time of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 2/10/22 at 1:34 P.M., and indicated the Administrator notified her by phone that something was going on at the facility related to a fall or something, and requested she go to the facility to check on the incident. The DON indicated Certified Nursing Assistant (CNA) 8 notified Clinical Manager (CM) 1 that CNA 9 was with Resident B in the bathroom when his prosthetic leg broke and he was lowered to the floor. The DON indicated she interviewed Resident B and the resident reported he was fine and not hurt, he just did not want LPN 8 to take care of him anymore. The DON indicated in her interview with LPN 8, the LPN reported Resident B was having behaviors and indicated the resident refused his medications and that she was just talking to the resident. The DON indicated LPN 8 did not want to write a statement until the CNAs made their report. The DON indicated that she did not ask LPN 8 if she yelled at Resident B, or if she had been abusive in any way. The DON indicated she did not interview CNA 8 because she was upset and CM1 sent her to take a break and calm down. The DON indicated she did not interview CNA 9 because she must have been doing patient care somewhere. DON indicated she got some staff witness statements, but couldn't get them all and instructed the the unit manager, LPN 9, to finish getting statements. DON indicated she was investigating in the facility on 2/23/22 from 4:30 P.M. to 6:00 P.M. The DON indicated she did not find any concerns regarding the incident, so she allowed LPN 8 to remain at work but moved her from Resident B's care to work in a different hall, 100 Hall. The following day after collecting the rest of the statements from staff, she discussed the incident with the Administrator and determined there was a problem and suspended LPN 8 at that time, pending an investigation. DON indicated LPN 8 never provided a statement, and never returned to work at the facility after the incident. The DON indicated LPN 8 should have been suspended pending an investigation at the time of the incident. During a telephone interview with CNA 8, on 2/14/22 at 2:21 P.M., she indicated she was called to Resident B's room because he had fallen in the bathroom when his prosthetic leg broke, and CNA 9 needed help getting the resident up off the floor. CNA 8 indicated while she and other aides were in the room, LPN 8 indicated Resident B's fall was behavioral and he fell on purpose. CNA 8 further indicated that LPN 8 yelled at the resident asking if he wanted his pills or not. The resident told her he wanted them but not while he was still on the floor. CNA 8 indicated LPN 8 continued to tell the resident it was his fault that he fell and that it was a behavior. CNA 8 indicated LPN 8 screamed and said she doesn't respond to someone yelling at her and told every one to leave the resident alone while he was still on the floor. CNA 8 indicated she returned to her unit and called her unit manager, CM1 to report the incident and for guidance. On 2/17/22 at 10:44 A.M., CM1 indicated she received a call from CNA 8 who said LPN 8 was yelling at Resident B after he fell in the bathroom and that LPN 8 was trying to force him to take his meds while he was still on the ground. CM 1 indicated she was not at work that day, so she immediately reported the incident to the Administrator by phone. CM 1 indicated the DON went to the facility to investigate, but allowed LPN 8 to continue working though moved her from Resident B's care. CM 1 indicated LPN 8 should have been removed from the facility pending an investigation. The facility's investigation file was provided by the DON on 2/17/22 at 2:00 P.M., and reviewed at that time. The staffing sheet in the file indicated LPN 8 worked on 1/23/22 from 2:00 P.M. to 10:00 P.M. on 100 Hall, and again from 10:00 P.M. to 6:30 A.M., on 100/400 Halls. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident Report dated 1/24/22 at 4:01 P.M., indicated Resident B's roommate's friend reported to the DON today that she had concerns with the interaction of the staff person and Resident B. The roommate's friend reported that the nurse was rude and antagonistic towards the resident. Immediate action taken; on 1/24/22 Nurse suspended. Interviews conducted and investigation initiated. Head to toe assessment completed on resident. The clinical record for Resident B was provided by the DON on 2/10/22 at 10:00 A.M., and reviewed at that time. The most recent comprehensive Minimum Data Set (MDS), was a Quarterly assessment dated [DATE]. The MDS indicated Resident B was cognitively intact, had adequate hearing and speech, was able to understand others, while making himself understood, had no behaviors, required extensive assistance with most activities of daily living. Resident B required assistance for transfers and balance. Diagnoses included but were not limited to blindness and below the knee amputations to both legs. Resident B utilized prosthetics to both legs. Review of a Progress note dated 1/24/22 at 4:49 P.M., and signed by the DON, indicated Resident's roommate's fiance came in to visit and asked her about fall and incident that occurred on 1/23/21 [1/23/22]. She voiced concerns about the unprofessionalism of LPN 8. She found her to be rude and antagonistic. On 2/8/22 at 11:20 A.M., the DON provided a policy titled, Policies and Standard Procedures Subject: INDIANA Abuse & Neglect & Misappropriation of Property, dated 9/1/17 and most recently revised on 10/27/2021. The policy indicated, .In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation .4. An employee who is alleged or accused of being a party to abuse .will be immediately removed from the area of resident care, interviewed by facility leadership for a written statement and not left alone .5. After completing the statement, the employee will be asked to vacate the facility until further investigation of the incident is completed This Federal tag relates to complaint IN00371647. 3.1-28(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based interview, and record review, the facility failed to ensure a thorough investigation was completed for an allegation of abuse for 1 of 5 residents reviewed for abuse, (Resident B). Finding includes: During an interview on 2/9/22 at 11:47 A.M., Resident B indicated he was blind and required assistance for activities of daily living including assistance to use the restroom. The resident indicated on 1/23/22, sometime in the afternoon, he was being assisted in the bathroom, slipped and let himself down on the bathroom floor. Resident B indicated 2 aides were trying to help him get to his chair when Licensed Practical Nurse (LPN) 8 entered the room and told him to take his medications at that time. The resident indicated he told LPN 8 he would take his medications when the aides got him off the floor and into his chair, he did not want to take the medications while sitting on the floor. Resident B indicated LPN 8 became angry, yelled at him saying he had behavior issues and accused him of refusing medications. The resident indicated LPN 8 kicked everyone out of the room. Resident B indicated staff returned to the room and transferred him to bed using the mechanical lift. Resident B indicated he felt safe at the facility but worried nurses could make mistakes and he did not want LPN 8 to ever come in to his room again. During an interview on 2/10/2022 at 1:25 P.M., the Administrator indicated he was notified by phone of the incident on Sunday, 1/23/22 right after the occurrence and notified the Director of Nursing (DON), to go to the facility to assess the incident. The Administrator indicated the DON did not find any concerns at that time and did not trigger an investigation until the following day after interviews. After the DON interviewed staff she realized she needed to make a report to the State Agency. The Administrator indicated LPN 8 was allowed to work the remained of the 2:00 P.M. to 10:00 P.M. shift but her assignment was changed so she would no longer be caring for Resident B. The Administrator indicated in retrospect, LPN 8 should probably have been sent home at the time of the incident. The DON was interviewed on 2/10/22 at 1:34 P.M., and indicated the Administrator notified her by phone that something was going on at the facility related to a fall or something, and requested she go to the facility to check on the incident. The DON indicated Certified Nursing Assistant (CNA) 8 notified Clinical Manager (CM) 1 that CNA 9 was with Resident B in the bathroom when his prosthetic leg broke and he was lowered to the floor. The DON indicated she interviewed Resident B and the resident reported he was fine and not hurt, he just did not want LPN 8 to take care of him anymore. The DON indicated during her interview with LPN 8, the LPN reported Resident B was having behaviors and indicated the resident refused his medications and that she was just talking to the resident. The DON indicated LPN 8 did not want to write a statement until the CNAs made their report. The DON indicated that she did not ask LPN 8 if she yelled at Resident B, or if she had been abusive in any way. The DON indicated she did not interview CNA 8 because she was upset and CM1 sent her to take a break and calm down. The DON indicated she did not interview CNA 9 because she must have been doing patient care somewhere. DON indicated she got some staff witness statements, but couldn't get them all and instructed the the unit manager, LPN 9, to finish getting statements. DON indicated she was investigating in the facility on 2/23/22 from 4:30 P.M. to 6:00 P.M. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON indicated she did not find any concerns regarding the incident, so allowed LPN 8 to remain at work but moved her from Resident B's care to work in a different hall, 100 Hall. DON indicated the following day after collecting the rest of the statements from staff, she discussed the incident with the Administrator and determined there was a problem and suspended LPN 8 at that time, pending an investigation. DON indicated LPN 8 never provided a statement, and never returned to work at the facility after the incident. The DON indicated LPN 8 should have been suspended pending an investigation at the time of the incident. During an interview on 2/10/22 at 3:29 P.M., DON indicated the incident was reported on 1/24/22 at 4:01 P.M. , and that the time of the incident was incorrectly reported as 1/24/22 at 4:01 P.M The DON indicated the incident actually occurred on 1/23/22 at 4:00 P.M. During a telephone interview with CNA 8, on 2/14/22 at 2:21 P.M., she indicated she was called to Resident B's room because he had fallen in the bathroom when his prosthetic leg broke, and CNA 9 needed help getting the resident up off the floor. CNA 8 indicated while she and other aides were in the room, LPN 8 indicated Resident B's fall was behavioral and he fell on purpose. CNA 8 further indicated that LPN 8 yelled at the resident asking if he wanted his pills or not. The resident told her he wanted them but not while he was still on the floor. CNA 8 indicated LPN 8 continued to tell the resident it was his fault that he fell and that it was a behavior. CNA 8 indicated LPN 8 screamed and said she doesn't respond to someone yelling at her and told every one to leave the resident alone while he was still on the floor. CNA 8 indicated she returned to her unit and called her unit manager, CM1 to report the incident and for guidance. On 2/17/22 at 10:44 A.M., CM1 indicated she received a call from CNA 8 who said LPN 8 was yelling at Resident B after he fell in the bathroom and that LPN 8 was trying to force him to take his meds while he was still on the ground. CM 1 indicated she was not at work that day, so she immediately reported the incident to the Administrator by phone. CM 1 indicated the DON went to the facility to investigate, but allowed LPN 8 to continue working though moved her from Resident B's care. CM 1 indicated LPN 8 should have been removed from the facility pending an investigation. The facility's investigation file was provided by the DON on 2/17/22 at 2:00 P.M., and reviewed at that time. The staffing sheet in the file, indicated LPN 8 worked on 1/23/22 from 2:00 P.M. to 10:00 P.M. on 100 Hall and again from 10:00 P.M. to 6:30 A.M. on 100/200 hall. Resident B resided on 200 Hall. An Incident Report, dated 1/24/22 at 4:01 P.M , indicated Resident B's roommate's friend reported to the DON today that she had concerns with the interaction of the staff person and Resident B. The roommate's friend reported that the nurse was rude and antagonistic towards the resident. Immediate action taken; on 1/24/22 Nurse suspended. Interviews conducted and investigation initiated. Head to toe assessment completed on resident. The clinical record for Resident B was provided by the DON on 2/10/22 at 10:00 A.M., and reviewed at that time. The most recent comprehensive Minimum Data Set (MDS), was a Quarterly assessment dated [DATE]. The MDS indicated Resident B was cognitively intact, had adequate hearing and speech, was able to understand others, while making himself understood, had no behaviors, required extensive assistance with most activities of daily living. Resident B required assistance for transfers and balance. Diagnoses included but were not limited to blindness and below the knee amputations to both legs. Resident 8 utilized prosthetics to both legs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note dated 1/24/22 at 4:49 P.M., and signed by the DON, indicated Resident's roommate's fiance came in to visit and asked her about a fall and incident that occurred on 1/23/21 [1/23/22]. She voiced concerns about the unprofessionalism of LPN 8. She found her to be rude and antagonistic. On 2/8/22 at 11:20 A.M., the DON provided a policy titled, Policies and Standard Procedures Subject: INDIANA Abuse & Neglect & Misappropriation of Property, dated 9/1/17 and most recently revised on 10/27/2021. The policy indicated, .In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation .4. An employee who is alleged or accused of being a party to abuse .will be immediately removed from the area of resident care, interviewed by facility leadership for a written statement and not left alone .5. After completing the statement, the employee will be asked to vacate the facility until further investigation of the incident is completed .1. In the event a staff member has been accused, the member will be interviewed by the Executive Director or designee and immediately escorted from the facility. a. The staff member will be suspended, by the Executive Director or designee, pending the outcome of the investigation of the incident . This Federal tag relates to complaint IN00371647. 3.1-28(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34966 Based on observation, interview, and record review, the facility failed to ensure facility meal menus were followed, menus were posted, and substitutions were offered for 84 of 86 residents who ate meals provided by the facility dietary. Finding includes: On 2/7/22 at 12:45 P.M., during an observation and interview, Resident N's meal tray was on the over-the-bed table. The meal included an unknown shredded meat, cooked carrots, mashed potatoes, and canned pears. Resident N had only eaten the pears, and indicated he was supposed to have something else for lunch, but got this. Resident N indicated he did not like the food and what was served never matched the meal ticket that came with the meal. Resident N indicated menus were not provided and residents do not know what the meal will be until it the tray is delivered. Resident N indicated the facility did not provide alternates and if an alternate is requested, the dietary staff refuses. During an observation and interview, on 2/7/22 at 12:50 p.m., Resident P had a meal tray on the over-the-bed table with shredded meat, cooked carrots, mashed potatoes, and canned pears. A review of the resident's meal ticket indicated the meal served was encrusted pork loin, roasted brussels sprouts, bread dressing, dinner roll, orange sherbet. The resident indicated the facility did not offer substitutes and if residents did not like what was served they were not given anything else to eat. Resident P indicated a lot of times what is printed on the meal ticket is not what is served. Resident P indicated the facility did not offer snacks in the daytime or in the evening. During an observation and interview, on 2/7/22 at 1:03 P.M., Resident R's meal tray was noted to have shredded meat, cooked carrots, mashed potatoes, and pears. A review of the resident's meal ticket indicated the meal served was encrusted pork loin, roasted brussels sprouts, bread dressing, dinner roll, orange sherbet. Resident R indicated he did not like the meal and was not going to eat it. Resident R indicated the meal ticked that comes with the tray never matched the meal served and that maybe residents can ask for an alternative, but he has never been able to get one. Resident R indicated he has never seen a meal menu in the facility. During an observation and interview, on 2/7/22 at 1:10 P.M., Resident S's meal tray was noted to have shredded meat, cooked carrots, mashed potatoes, and pears. A review of the resident's meal ticket indicated the meal served was encrusted pork loin, roasted brussels sprouts, bread dressing, dinner roll, orange sherbet. The resident indicated residents don't usually get what is on the meal ticket. Resident S indicated he could not order an alternate. During an interview on 2/7/22 at 1:20 P.M., Resident T indicated she has never seen a menu at the facility and that residents only get what is served and no alternates are offered. Resident T indicated the facility does not supplies snacks and gets hungry before breakfast is served. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Healthcare Center	333 W Mishawaka Rd Elkhart, IN 46517

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/7/22 at 2:20 P.M., Cook 1 indicated menus were generated at the facility's home office and not at the facility. Cook 1 indicated the supply truck usually delivered on Tuesday and Friday, but did not always arrive on time, so dietary staff had to find something else to serve, so the meal does not match the menu or meal tickets. Cook 1 indicated she did not post menus and did not send menus to the residents. Cook 1 indicated she made alternates on the days she works, but did not know if the other cooks did. During an interview,on 2/8/22 at 10:29 A.M., the Corporate Registered Dietician (CRD) indicated the facility used a menu cycle, but food availability is just not there, so they have to use substitutes. The CRD indicated residents should have menus available to them to know what is on the menu and also what the substitutions are. The CRD indicated the facility should be offering evening snacks since there is over 14 hours between Dinner and breakfast. A policy entitled Dining Services Department Policy and Procedure Manual, dated 9/2017, was provided by the Corporate Registered Dietician on 2/8/22 at 11:15 A.M., and reviewed at that time. The policy indicated, . 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. 8. Menus will be posted in the Dining Services department, dining rooms and resident/patient care areas .Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value .Procedures .2. Schedule of meal service times will be provided to the nursing staff and available in resident/patient care areas This Federal tag relates to Complaint IN00368256. 3.1-20(i)(2)(4) 3.1-20(k) 3.1-21(4)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 34966 Based on interview and record review, the facility failed to ensure a substantial snack was offered to residents at bedtime daily when there were more than 14 hours between the evening meal and breakfast the next day. This deficient practice had the potential to affect 84 of 86 residents who had meals provided by the facility. Findings include: During an interview on 12/7/22 at 12:45 P.M., Resident O indicated the residents are not offered snacks at the facility. During an interview on 2/7/22 at 12:50 P.M., Resident P indicated the facility did not offer snacks in the daytime or in the evening. During an interview on 2/7/22 at 1:10 P.M., Resident S indicated he had never been offered a snack at the facility and indicated once in awhile they might have popcorn. During an interview on 2/7/22 at 1:20 P.M., Resident U indicated the facility does not supplies snacks and gets hungry before breakfast is served. During an interview on 2/7/21 at 1:20 P.M., Resident T indicated snacks were never offered at the facility and she gets hungry before breakfast comes. During an interview on 2/7/22 at 2:20 P.M., Cook 1 indicated she tries to have snacks on the units for residents, like a sandwich or something, if a resident gets hungry. Cook 1 indicated someone was eating the snacks, she thought it was the residents. On 2/7/22 at 2:20 P.M., the Administrator provided the facility current menus from 1/30/22 to 2/12/22. The Administrator wrote the meal service times on the menu as breakfast at 7:30 A.M., lunch at 11:45 A.M., and dinner at 5:00 P.M. The Administrator indicated these were the facility meal times. During an interview on 2/8/22 at 8:56 A.M., Resident N indicated it was a long time between supper and breakfast and he couldn't get a snack even if he asked for one. During an interview on 2/8/22 at 8:58 A.M., Resident G indicated that snacks were never offered at the facility and that he keeps his own snacks in case his blood sugar get low because he was a diabetic. During an interview on 2/8/22 at 10:29 A.M., the Corporate Registered Dietician indicated the facility should be offering evening snacks since there is over 14 hours between dinner and breakfast. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A policy entitled Dining Services Department Policy and Procedure Manual, dated 9/2017, was provided by the Corporate Registered Dietician on 2/8/22 at 11:15 A.M., and reviewed at that time. The policy indicated, . Procedures .5. A nourishing evening snack will be provided if the time span between dinner one night and breakfast the next morning exceeds 14 hours . This Federal tag relates to Complaint IN00368256. 3.1-21(d)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based on interview and record review, the facility failed to ensure their Facility Assessment Tool was followed when agency staff who worked in the facility as Certified Nursing Assistants and a Licensed Practical Nurse were certified and/or licensed according to Federal and State law from 9/29/21 to 1/15/22. The facility had 18 individuals working as Certified Nursing Assistants who were not certified. The facility also had 1 individual who worked as an LPN who was not licensed. These individuals performed the functions as if they were licensed. License and certifications were not verified by the facility. This deficient practice had the potential to affect all residents who resided in the facility from [DATE] to 1/15/22. Finding includes: During an interview on 2/9/22 at 2:08 P.M., Agency Staff 1 indicated she had taken a job with a local staffing agency after applying for a dietary position. The agency owner told her they needed Certified Nursing Assistants (CNA), Qualified Medication Aides (QMA), and Nurses. Agency Staff 1 indicated the owner of the local staffing agency told her the agency needed CNAs, QMAs, and Nurses. Agency Staff 1 indicated she told the agency owner she was not a CNA, QMA, or Nurse, and the agency owner said she could train her. Agency Staff 1 indicated she was given one day of training with the staffing agency and indicated she guessed she should have known better but didn't. During an interview on 2/9/22 at 2:40 P.M., the Administrator indicated some of the staff from the local staffing agency worked as CNAs, QMAs, and nurses in the facility. Agency staff 1 worked as a Licensed Practical Nurse (LPN) on 12/31/21, 1/3/22, 1/7/22, 1/8/22, 1/9/22, 1/10/22, and 1/11/22. The Administrator indicated there were other staff from the same agency that worked in the facility without licenses or certifications, but he did not say how many. When asked who was responsible for checking licenses, the administrator indicated himself and the human resources department. The Administrator indicated the facility did not check certification or licenses immediately. The discovery came when they began preparing for Federal Tag 888 and doing research on agency staff, immunizations, education, and licenses with the intent to make files for the agency staff. He Indicated this was when he discovered Agency Staff 1 did not have a nurse's license and began looking into the other agency employees at that time. During a second interview with Agency Staff 1, on 2/9/22 at 2:46 P.M., indicated she worked at the facility for a couple of months as a CNA and LPN. She indicated she had passed medications at the facility, and that most staff at the agency were uncertified and worked as aides, QMA's, and LPN's. Agency Staff 1 indicated most staff of the agency were members of the owner's family. During an interview on 2/9/22 at 4:15 P.M. with the Director of Nursing, she indicated she did not check nursing licenses nor certifications for staff who worked for the local staffing agency, and the facility probably should have checked to ensure licensure before the agency staff worked with facility residents. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on on 2/11/22 at 12:27 P.M., the Director of Nursing , provided documentation that indicated Agency Staff 1 worked in the capacity of a CNA on 11/23/21, and 11/26/21, and in the capacity of an LPN on 11/27/21, 11/28/21, 11/30/21, 12/1/21, 12/29/21, 12,31/21, 1/3/22, 1/7/22, 1/8/22, 1/9/22, 1/10/22, and 1/11/22. A license was unable to be verified through the State of Indiana's Professional Licensing Agency. On 11/27/21 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 2:00 P. M. to 10 P.M., where she administered medications and insulin to residents. On 11/28/21 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 6:00 A. M. to 2:00 P.M., where she administered medications and insulin to residents. On 11/30/21 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 400 Hall from 2:00 P. M. to 10: 00 P.M., where she administered medications to residents. On 12/1/21 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 2:00 P. M. to 10:00 P.M. where she administered medications and insulin to residents. On 12/29/21 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 300 Hall from 2:00 P. M. to 10:00 P.M. where she administered medications to residents. On 12/31/21 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 2:00 P. M. to 10: 00 P.M. and then 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. On 1/3/22 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 200 Hall from 2:00 P. M. to 10:00 P.M., where she administered medications to residents. On 1/7/22 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. 1/8/22 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P. M. to 6:00 A.M., where she administered medications to residents. 1/9/22 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P. M. to 6:00 A.M., where she administered medications to residents. 1/10/22 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. 1/11/22 Agency Staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/28/21, 10/29/21, 11/1/21, 11/3/21, 11/4/21, 11/5/21, 11/9/21,11/29/21, 12/8/21, 12/9/21, 12/15/21, 12/16/21, 12/17/21, 12/28/21, 12/29/21, 12/30/21 and indicated Agency Staff 2 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/20/21, 10/21/21, 10/23/21, 10/24/21, 10/26/21, 10/27/21, 10/28/21, 10/30/21, 10/31/21, 11/1/21, 11/3/21, 11/4/21, 11/6/21, 11/7/21,11/15, 11/16/21, 11/17/21, 11/20/21, 11/21/21, 11/22/21, 11/23/21, 11/26/21, 11/27/21, 11/28/21, 11/29/21, 11/30/21, 12/4/21, 12/5/21, 12/7/21, 12/8/21, 12/9/21, 12/11/21, 12/15/21, 12/16/21, 12/18/21, 12/19/21, 12/20/21, 12/22/21, and 12/23/21. Agency Staff 3 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/1/21,10/2/21, 10/4/21, 10/5/21, 10/14/21, 10/15/21, 10/17/21, 10/18/21, 10/19/21, 10/20/21, 10/21/21, 10/22/21, 10/24/21, 10/25/21, 10/26/21, 10/27/21, 10/28/21, 10/29/21, 10/30/21, 11/3/21, 11/4/21, and 11/5/21. Agency Staff 4 worked on those dates in the capacity of a Certified Nursing Assistant. A current license could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/1/21, 10/2/21, 10/31/21, 11/4/21, 11/5/21,11/6/21, 11/7/21, 11/14/21, 11/16/21, 11/17/21, 11/19/21, 11/20/21,11/23/21, 11/24/21, 11/25/21, 11/26/21, 11/27/21,11/30/21, 12/1/21, 12/3/21,12/4/21, 12/6/21, 12/7/21, 12/8/21, 12/9/21, 12/11/21, 12/21/21, 12/22/21, 12/23/21, 12/24,21, 12/26/21, 12/27/21, 12/28/21, and 1/22/22. Agency Staff 5 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/21 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/15/21, 10/18/21, 10/19/21, 10/20/21, 10/22/21, 10/23/21, 10/28/21, 10/29/21, 10/30/21, 11/1/21, 11/2/21, 11/3/21, 11/4/21, 11/6/21, 11/7/21, 11/22/21, 11/23/21, 11/24/21, 11/25/21, 11/27/21, 12/1/21, 12/2/21, 12/3/21, 12/4/21, 12/18/21, 12/20/21, 12/21/21, 12/22/21, 12/23/21, 12/24/21, and 12/25/21. Agency Staff 6 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was unsigned by the agency employee but signed by the agency supervisor and facility employee for 12/4/21 and signed by the agency employee and facility staff on 12/7/21, 12/10/21, and 12/11/21. Agency Staff 7 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/4/21, 10/5/21, 10/13/21,10/14/21, 10/16/21, 10/17/21, 10/18/21, 10/24/21, 11/1/21, 11/2/21, 11/3/21, 11/6/21, 11/23/21, 11/24/21, 11/25/21, 11/27/21, 12/6/21, 12/7/21, 12/8/21, and 12/9/21. Agency Staff 8 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/20/21, 10/21/21, 10/22/21, 10/23/21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/4/21, 11/5/21 and 11/7/21. Agency Staff 9 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 12/24/21. Agency Staff 10 worked on this date in the capacity of a Certified Nursing assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/19/21, 10/20/21, 10/31/21, 11/1/21, 11/4/21, 11/6/21, 11/7/21, 11/8/21, 12/7/21, 12/9/21, 12/11/21, 12/16/21, 12/17/21, 12/27/21, 12/31/21 and 1/1/22. Agency Staff 11 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/9/21, 10/15/21, 10/16/21, 10/18/21, 10/26/21, 10/27/21, 11/3/21, 11/4/21 and 11/5/21. Agency Staff 12 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee and facility staff and dated for 11/3/21, and 11/4/21. Agency Staff 13 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by agency employee and facility staff and dated 9/29/21, 11/28/21, 11/29/21, 11/30/21, and 12/2/21. Agency Staff 14 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by agency employee and facility staff and dated 11/3/21, 11/4/21 and 11/5/21. Agency Staff 15 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 11/3/21, 11/4/21, 11/5/21, 11/6/21, 12/16/21, 12/17/21, 12/18/21, 12/19/21 and 12/31/21. Agency Staff 16 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 12/20/21, 12/21/21 and 12/29/21. Agency Staff 17 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 10/10/21, 10/11/21, 10/12/21, 10/13/21, 10/14/21, 10/17/21, 10/30/21, 11/1/21, 11/2/21, 11/4/21 and 11/6/21. Agency Staff 18 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 11/2/21 and 11/5/21. Agency Staff19 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. The Facility Assessment Tool dated 10/2021 through 9/2022, was provided by the Administrator on 2/14/22 at 11:00 A.M., and reviewed at that time. The Facility Assessment Tool directs the facility to, .Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies .Attachment 1 Medicare and Medicaid Programs; Reform of Requirement for Long-Term Care Facilities Federal Register/Vol.81, No.192/Tuesday, October 4 2016'/Rules and Regulations .Nursing Services 483.35 - The facility must have sufficient nursing staff with the appropriate competencies and skill set to provide nursing and related services to assure resident safely and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident . This Federal tag relates to complaint IN00372368.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Healthcare Center	333 W Mishawaka Rd Elkhart, IN 46517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based on interview and record review, the facility failed to ensure agency staff who worked in the facility as Certified Nursing Assistants and a Licensed Practical Nurse were certified and/or licensed according to Federal and State law from 9/29/21 to 1/15/22. The facility had 18 individuals working as Certified Nursing Assistants who were not certified. The facility also had 1 individual who worked as an LPN who was not licensed. These individuals performed the functions as if they were licensed. License and certifications were not verified by the facility. This deficient practice had the potential to affect all residents who resided in the facility from [DATE] to 1/15/22. The immediate jeopardy began on 9/29/21 when the first uncertified nursing assistant began working with residents. The Administrator was notified of the immediate jeopardy on 2/11/22 at 2:25 P.M. Finding includes: During an interview, conducted with Agency Staff 1, on 2/9/22 at 2:08 P.M., she indicated she had taken a job with a local staffing agency after applying for a dietary position. The agency owner told her they needed Certified Nursing Assistants (CNA), Qualified Medication Aides (QMA), and Nurses. She told the owner she did not have training in those areas and the agency owner told her she could train her, and she was given one day of training. She indicated she guessed she should have known better but she didn't. During an interview, conducted with the Administrator of the facility, on 2/9/22 at 2:40 P.M., he indicated some of the staff from (local staffing agency) worked as CNA's, QMA's, and nurses in the facility. Agency staff 1 worked as an LPN on 12/31/21, 1/7/22, 1/8/22, 1/9/22, 1/10/22, and 1/11/22. He indicated there were other staff from the same agency that worked in the facility without licenses or certifications, but he did not say how many. When asked who was responsible for checking licenses, he indicated himself and the human resources department. He indicated the facility did not check certification or licenses immediately. The discovery came when they began preparing for F888 and doing research on Agency staff, immunizations, education, and licenses with the intent to make files for the agency staff. He Indicated this was when he discovered Agency Staff 1 did not have a nurse's license, they began looking into the other agency employees at that time. During a second interview with Agency staff 1, on 2/9/22 at 2:46 P.M., she indicated she worked at (local facility) for a couple of months as a CNA and LPN. She indicated she had passed medications at (local facility), and that mostly everyone from the staffing agency was uncertified and working as aides and QMA's, and LPN's, she alleged most staff of the agency were members of the owner's family. During a second interview, conducted with the Administrator of the facility on 2/10/22 at 4:36 P.M., he indicated he had not reported the occurrence to the State of Indiana, and he probably should have. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview, with the Director of Nurses (DON), on 2/11/22 at 12:27 P.M., she provided documentation that indicated Agency staff 1 worked in the capacity of a CNA on 11/23/21, 11/26/21 and in the capacity of a Licensed Practical Nurse on 11/27/21, 11/28/21, 11/30/21, 12/1/21, 12/29/21, 12,31/21, 1/3/22, 1/7/22, 1/8/22, 1/9/22, 1/10/22, and 1/11/22. A license was unable to be verified. On 11/27/21 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 2:00 P. M. to 10 P.M., where she administered medications and insulin to residents. On 11/28/21 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 6:00 A. M. to 2:00 P.M., where she administered medications and insulin to residents. On 11/30/21 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 400 Hall from 2:00 P. M. to 10: 00 P.M., where she administered medications to residents. On 12/1/21 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 2:00 P. M. to 10:00 P.M. where she administered medications and insulin to residents. On 12/29/21 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 300 Hall from 2:00 P. M. to 10:00 P.M. where she administered medications to residents. On 12/31/21 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100 Hall from 2:00 P. M. to 10: 00 P.M. and then 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. On 1/3/22 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 200 Hall from 2:00 P. M. to 10:00 P.M., where she administered medications to residents. On 1/7, 22 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. 1/8/22 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P. M. to 6:00 A.M., where she administered medications to residents. 1/9/22 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P. M. to 6:00 A.M., where she administered medications to residents. 1/10/22 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. 1/11/22 Agency staff 1 worked in the capacity of a Licensed Practical Nurse on the 100/400 Hall from 10:00 P.M. to 6:00 A.M., where she administered medications to residents. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/28/21, 10/29/21, 11/1/21, 11/3/21, 11/4/21, 11/5/21, 11/9/21,11/29/21, 12/8/21, 12/9/21, 12/15/21, 12/16/21, 12/17/21, 12/28/21, 12/29/21, 12/30/21 and indicated Agency staff 2 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/20/21, 10/21/21, 10/23/21, 10/24/21, 10/26/21, 10/27/21, 10/28/21, 10/30/21, 10/31/21, 11/1/21, 11/3/21, 11/4/21, 11/6/21, 11/7/21,11/15, 11/16/21, 11/17/21, 11/20/21, 11/21/21, 11/22/21, 11/23/21, 11/26/21, 11/27/21, 11/28/21, 11/29/21, 11/30/21, 12/4/21, 12/5/21, 12/7/21, 12/8/21, 12/9/21, 12/11/21, 12/15/21, 12/16/21, 12/18/21, 12/19/21, 12/20/21, 12/22/21, and 12/23/21. Agency staff 3 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/1/21,10/2/21, 10/4/21, 10/5/21, 10/14/21, 10/15/21, 10/17/21, 10/18/21, 10/19/21, 10/20/21, 10/21/21, 10/22/21, 10/24/21, 10/25/21, 10/26/21, 10/27/21, 10/28/21, 10/29/21, 10/30/21, 11/3/21, 11/4/21, and 11/5/21. Agency staff 4 worked on those dates in the capacity of a Certified Nursing Assistant. A current license could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/1/21, 10/2/21, 10/31/21, 11/4/21, 11/5/21,11/6/21, 11/7/21, 11/14/21, 11/16/21, 11/17/21, 11/19/21, 11/20/21,11/23/21, 11/24/21, 11/25/21, 11/26/21, 11/27/21,11/30/21, 12/1/21, 12/3/21,12/4/21, 12/6/21, 12/7/21, 12/8/21, 12/9/21, 12/11/21, 12/21/21, 12/22/21, 12/23/21, 12/24,21, 12/26/21, 12/27/21, 12/28/21, and 1/22/22. Agency staff 5 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/21 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by the agency employee and facility staff and dated for 10/15/21, 10/18/21, 10/19/21, 10/20/21, 10/22/21, 10/23/21, 10/28/21, 10/29/21, 10/30/21, 11/1/21, 11/2/21, 11/3/21, 11/4/21, 11/6/21, 11/7/21, 11/22/21, 11/23/21, 11/24/21, 11/25/21, 11/27/21, 12/1/21, 12/2/21, 12/3/21, 12/4/21, 12/18/21, 12/20/21, 12/21/21, 12/22/21, 12/23/21, 12/24/21, and 12/25/21. Agency staff 6 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was unsigned by the agency employee but signed by the agency supervisor and facility employee for 12/4/21 and signed by the agency employee and facility staff on 12/7/21, 12/10/21, and 12/11/21. Agency staff 6 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/4/21, 10/5/21, 10/13/21,10/14/21, 10/16/21, 10/17/21, 10/18/21, 10/24/21, 11/1/21, 11/2/21, 11/3/21, 11/6/21, 11/23/21, 11/24/21, 11/25/21, 11/27/21, 12/6/21, 12/7/21, 12/8/21, and 12/9/21. Agency staff 8 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/20/21, 10/21/21, 10/22/21, 10/23/21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/4/21, 11/5/21 and 11/7/21. Agency staff 9 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 12/24/21. Agency staff 10 worked on those dates in the capacity of a Certified Nursing assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/19/21, 10/20/21, 10/31/21, 11/1/21, 11/4/21, 11/6/21, 11/7/21, 11/8/21, 12/7/21, 12/9/21, 12/11/21, 12/16/21, 12/17/21, 12/27/21, 12/31/21 and 1/1/22. Agency staff 11 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee staff and facility staff and dated for 10/9/21, 10/15/21, 10/16/21, 10/18/21, 10/26/21, 10/27/21, 11/3/21, 11/4/21 and 11/5/21. Agency staff 12 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M. The time sheet was signed by agency employee and facility staff and dated for 11/3/21, and 11/4/21. Agency staff 13 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by agency employee and facility staff and dated 9/29/21, 11/28/21, 11/29/21, 11/30/21, and 12/2/21. Agency staff 14 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by agency employee and facility staff and dated 11/3/21, 11/4/21 and 11/5/21. Agency employee 15 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 11/3/21, 11/4/21, 11/5/21, 11/6/21, 12/16/21, 12/17/21, 12/18/21, 12/19/21 and 12/31/21. Agency Employee 16 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 12/20/21, 12/21/21 and 12/29/21. Agency employee 17 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 10/10/21, 10/11/21, 10/12/21, 10/13/21, 10/14/21, 10/17/21, 10/30/21, 11/1/21, 11/2/21, 11/4/21 and 11/6/21. Agency employee 18 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Employee Time Sheet, provided by the DON, on 2/11/22 at 9:30 A.M., was reviewed on 2/11/22 at 12:35 P.M., the time sheet was signed by the agency employee and facility staff and dated 11/2/21 and 11/5/21. Agency employee 19 worked on those dates in the capacity of a Certified Nursing Assistant. A current certification could not be verified. An Agency Agreement/Contract, dated 8/24/21, was provided by the DON on 2/11/22 at 2:00 P.M. The policy indicated .Provider's Responsibilities: 2. Provider shall only provide personnel who meet the requirements of Customer as defined in Attachment A. d. Verification that evidence of the professional licensure identification, as applicable has been seen and examined. 4. Provider is responsible for evaluating skills and experience of its nursing personnel. Provider will match the skills and experience level of its employees to the specific needs of the customer. Customer Responsibilities: 5. Customer agrees the Provider's duty to fill assignments is subject to the availability of qualified personnel. III. Mutual Responsibilities: 1. The parties shall comply with all federal, state and local laws and regulations including but not limited to, Title [NAME] of the Civil Rights Act, The National Labor Relations Act, and the Health Insurance Portability and Accountability Act of 1996 A policy, titled .Staffing Agency Use, with a revision date of 11/22/21, was provided by the DON on 2/11/22 at 2:00 P.M. The policy indicated .The purpose of this policy is to provide guidance for using an outside agency to provide qualified and competent staff during periods when additional staff is required. The Director of Nursing (D.O.N.) will be responsible for providing safe and competent staff to fill positions with interim or agency staff. Procedure: C. The D.O.N./designee will obtain, at a minimum, basic information from the agency including name, contact information, license information including license number and type, COVID vaccination card or medical or religious exemption, previous training including HIPPA, Universal Precautions and Medication Administration Safety and any current experience. D. The facility will obtain and maintain a file on each person working in the facility as a staffing agency. F. The facility will obtain current state license verification prior to the nurse starting the shift This Federal tag relates to Complaint IN00372368. 3.1-14(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 34966 Based on record review and interview, the facility failed to implement an Antibiotic Stewardship Program that monitored the appropriate use of antibiotics, and failed to track and monitor infections for outbreaks. This deficient practice had the potential to affect 86 of 86 residents who reside in the facility. Finding includes: On 2/10/22 at 10:00 A.M., the Director of Nursing (DON), indicated she is the facility's Infection Preventionist (IP), and is in charge of the Antibiotic Stewardship program. The DON indicated tracking of antibiotics should be complete, but the process is behind. The Infection Control Surveillance book was requested on 2/10/22 at 10:00 A.M. On 2/10/22 at 2:06 P.M., the DON provided incomplete antibiotic tracking sheets for 12/21 and 1/22 that were reviewed at that time. The Infection Control Surveillance Log for 12/21 and 1/22 were void of any information. The Line Listing of resident infections, dated 12/21, indicated 7 residents with infections. 7 of 7 residents had the antibiotic they were using listed,but did not include the dose and strength, and the antibiotic start date. 2 residents also had an antibiotic stop date. 7 of 7 residents did not have listed the infection site, culture date or results, organisms from cultures, necessary isolation, information meeting McGreer's Criteria, and care plans. 5 of 7 residents did not have a stop date or duration time. The Line Listing of resident infections, dated 1/22, indicated 7 residents with infections. 7 of 7 residents had the antibiotic they were using listed, but did not include dose and strength. 5 of 7 resident had the antibiotic start date. 5 of 7 residents had an antibiotic stop date. 2 of 7 residents had the infection site noted. 0 of 7 had culture date, 1 of 7 indicated no organism. 6 of 7 had no or results, organisms from cultures. 2 of 7 indicated isolation. 0 of 7 included information meeting McGreer's Criteria, and care plans. information meeting McGreer's Criteria, or care plans. 2 of 7 residents did not have a stop date or duration time. Facility maps attached to the Infection Control Surveillance Long and the Antibiotic Review sheets for 12/21 and 1/22, where void of any mapping or information. On 2/11/22 at 10:19 A.M., the DON provided a policy entitled, Policies and Standard Procedures Subject: Surveillance for Infections, dated 10/29/2013 and reviewed 1/16/2020, was reviewed at that time. The policy indicated, .1. The IP/IP Designee will a. Review new antibiotic ordered: i. Review proper information including but not limited to:1. Reason for the antibiotic a. Empirically ordered i. Include Antibiotic Time-Out Review b. Lab validation prescribed. 2. Length of duration including start and stop dates 3. Dose and strength 4. Name and date of prescriber. II. Monitoring Infection activity: a. The infection log is used to identify and record infections and symptoms i. The tracking of Healthcare associated infections and infections of residents admitted to the center are recorded with the resident name, room #, admitted , date of onset, site, signs and symptoms, culture results, and treatment. ii. Data is monitored and patterns of cross-contamination identified, if able . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This Federal tag relates to complaint IN00370151.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 34966 Based on interview and record review, the facility failed to ensure the designated Infection Preventionist had completed specialized training in infection prevention and control. This deficient practice had the potential to affect 86 of 86 residents who resided in the facility. Finding includes: In an interview on 2/14/22 at 8:30 A.M., the Director of Nursing (DON) indicated she began employment at the facility on 12/20/21 and was instructed to complete her Infection Preventionist Training to become the facility's infection preventionist. The DON indicated she is working as the facility's Infection Preventionist, and that she had not had time to complete the training. The DON indicated she was aware the Infection Preventionist required specialized training and certification. The DON indicated the facility did not currently have a fully trained and certified Infection Preventionist. On 2/11/22 at 10:19 A.M., the DON provided the facility policy entitled, Policies and Standard Procedures Subject: Infection Prevention Program, and was reviewed at that time. The policy indicated, .IP: Infection Preventionist-An RN qualified by training and experience to oversee the infection prevention program for the facility .Procedure 1. e. iii A dedicated Infection Preventionist with specialized training for surveillance, educations and monitoring .i.i. Infection Preventionist is a dedicated nurse with the ability to assess and analyze resident data .I.iii. The IP has knowledge , competence, interest in infection prevention, and appropriate qualifications This Federal tag relates to complaint IN00370151.