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	02/09/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to transcribe and implement physician ordered hydration, nutrition and medications for a newly admitted resident. This practice resulted in the resident being hospitalized with a hyperosmolar hyperglycemic state (a critical, often fatal, complication from type 2 diabetes defined by severe hyperglycemia [high blood sugar] and extreme dehydration) that included a blood sugar level of 954 milligrams per deciliter (mg/dL) and extreme hypovolemic depletion (loss of extracellular fluid such as blood/salt/water) for 1 of 3 residents reviewed for quality of care. (Resident B) This practice had the potential to affect all newly admitted residents. The immediate jeopardy began on 1/4/26 when the facility failed to record and implement admission orders for critical medications and nutrition/hydration. The Administrator, Director of Nursing and Regional Director of Clinical Services were notified of the immediate jeopardy on 2/6/2026 at 12:00 P.M. The Immediate Jeopardy was removed, on 2/7/26 at 10:15 A.M., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes:A closed record review for Resident B was completed on 2/4/2026 at 10:55 A.M. Diagnoses included, but were not limited to: hemiplegia following a cerebral infarction (stroke), diabetes mellitus type 2, gastrostomy and dysphagia.Resident B was admitted to the facility on [DATE] from a rehabilitation hospital.A Discharge with Return Anticipated Minimum Data Set (MDS) assessment, dated 1/8/2025, indicated Resident B was comatose and eating assistance was not applicable due to having a feeding tube. Cognitive status could not be established due to Resident B's primary language being Russian.A Nursing Progress Note, on 1/4/2026 at 11:38 A.M., indicated Resident B had been admitted to the facility, was alert but nonverbal, had a feeding tube with continuous tube feeding with Vital 1.2 at 55 milliliters per hour.An Interdisciplinary Team Conference Note from the rehabilitation hospital, dated 12/23/2025 and provided to the facility at the time of the facility admission on [DATE], indicated the following medications were to be administered:- Levetiracetam (Keppra, anti-seizure medication) 500 milligrams twice daily- Aspirin 81 milligrams daily- Jardiance (a diabetic medication) 10 milligrams daily- Hydrochlorothiazide (a diuretic) 12.5milligrams daily- Lantus (long-acting) Insulin 100 units per milliliter inject 40 units every 12 hours subcutaneously- Lisinopril (hypertension medication) 40 milligrams daily- Metformin (a diabetic medication) 500 milligrams 2 tablets twice daily- Sodium Chloride (a supplement for low sodium level) 1 gram 2 tablets three times daily- Vital Advanced Formula 1.2 tube feeding 65 milliliters per hour continuously with a 25 milliliter per hour water flush.Physician Orders for Resident B were written on 1/6/2026 for the following medications:levetiracetam, sodium chloride, glargine (Lantus) insulin, Metformin, aspirin, hydrochlorothiazide, lisinopril, Jardiance and the water tube feeding flushes.There were no admission orders found in the Resident B's record prior to 1/6/26, despite having arrived to the facility on 1/4/26. A Medication Administration Record (MAR), dated January 2026, indicated glargine (morning (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dose), levetiracetam (afternoon dose) and metformin (evening dose) were administered on 1/6/2026. Aspirin, hydrochlorothiazide, Jardiance and lisinopril had an initial administration date of 1/7/2026. There were no other medications documented as given from 1/4-1/7/26.A Medication Administration Record (MAR), dated January 2026, indicated Jevity 1.2 per gastric tube at 85 milliliters per hour for 20 hours three times daily and 35 milliliters of water for 20 hours began on 1/7/2026 at 2:00 P.M. The MAR did not have any documentation of any tube feeding or water flushes having been administered from admission on [DATE] until 1/7/26.There was no documentation anywhere in the record that indicated the resident received any fluids or nutritional feedings from 1/4-1/7/26.A Care Plan, initiated on 1/6/2026, indicated Resident B had the potential for altered nutritional status related to problems for cerebral infarction, hypo-osmolarity, hyponatremia, diabetes mellitus type 2 and aphasia with interventions not limited to: receive/tolerate diet as ordered and remain free from of signs of dehydration.A Care Plan, initiated on 1/6/2026 and revised on 1/7/2026, indicated Resident B required tube feeding related to dysphagia. The goal was for Resident B to maintain adequate nutrition and hydration and remain free from complications. Interventions included, but were not limited to: administer flushes per medical provider's order, administer medications via tube per orders, provide tube feeding per medical provider orders and monitor intake of enteral tube feedings.There were no care plans for Resident B initiated prior to 1/6/26.A Nursing Progress Note, dated 1/8/2026 at 6:22 A.M., indicated the nurse had gone into Resident B's room to administer Resident B's medications and Resident B was observed to be sweaty, had an oxygen saturation level of 85 percent on room air, the nurse was unable to obtain a blood pressure and Resident B's blood sugar monitor indicated HI (high, unable to register blood sugar due the blood sugar exceeded the blood sugar monitor limit). The nurse called 911 to send Resident B to the emergency room for evaluation and treatment.A 72-hour Nursing Assessment had been completed on 1/7/2026 at 5:55 P.M. There were no other Nursing Assessments completed after Resident B's admission to the facility on 1/4/2026.An emergency room Urgent Care Note, dated 1/8/2026, indicated Resident B presented to the emergency department for evaluation of a fever, altered mental status, decreased responsiveness and blood sugar level. Laboratory tests results i the emergency room indicated a blood sugar level of 954 milligrams per deciliter (mg/dL), a blood urea nitrogen of 97 mg/dL, a creatinine level of 1.43 mg/dL, a sodium level of 150 millimoles per liter (mmol/L), a calcium level of 11 mg/dL and a hemoglobin level of 16.2 grams per deciliter (g/dL). Resident B had been admitted to the flexible acuity unit (step-down unit of critical care unit) for a hyperosmolar hyperglycemic state (a critical, often fatal, complication from type 2 diabetes defined by severe hyperglycemia, extreme dehydration and high serum osmolality without significant ketoacidosis), hypernatremia, extreme volume depletion and acute kidney injury.A Hospital Discharge summary, dated [DATE], indicated Resident B discharged from the hospital on 1/18/2026 (10 day hospitalization) to another rehabilitation facility on hospice (end of life palliative care) services.During an interview, on 2/6/2026 at 10:05 A.M., RN 2 indicated Resident B had been admitted to the facility on the weekend. When she audited Resident B's admission orders the following Monday, she noted the medication, tube feeding and hydration orders had not been initiated upon Resident B's admission. RN 2 indicated the medical record did not have any documentation that the medication, tube feeding or hydration had been administered during the time period of 1/4/2026-1/6/2026. She indicated Resident B should not have waited that long to have the physician orders implemented.A policy was provided, on 2/6/2026 at 11:54 A.M., by the Regional Director of Clinical Services. A current policy titled, admission Evaluation, indicated, .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. A systemic (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center.1. Complete the admission Initial UDA and appropriately triggered assessments electronically as as feasible but within 24 hours.2. Prioritize resident needs with appropriate interventions to include but not limited to: a. Meet immediate physical needs including assessment for pain.g. Complete medication reconciliation. h. Consider last meal eaten and provide hydration.A document, titled, admission Audit, was provided by the Regional Director of Clinical Services, on 2/8/2026 at 3:36 P.M. The audit tool indicated, .admission Progress Notes: Complete a progress note every shift for 72-hours, including vital signs and assessment of resident condition and interventions in place.The immediate jeopardy was removed and corrected on 2/7/2026 when the facility staff was in-serviced regarding enteral general nutrition guidelines, laboratory and radiological services, notification of change of conditions, admission evaluations, blood glucose point of care testing, physician orders, clinical morning meeting and admission audits, a house-wide clinical assessment of all residents completed, a review of all new resident admissions in the past two weeks and audits were implemented regarding newly admitted residents. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because the facility needed to continue audits to ensure ongoing compliance.This citation is related to Intake 2713578. 3.1-37(a)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to obtain physician ordered laboratory tests, including a urinalysis for 1 of 3 residents reviewed for laboratory service. (Resident C) This deficient practice resulted in a required hospitalization for uremic encephalopathy, hyperkalemia, acute kidney injury and acute hypoxic respiratory failure with pneumonia. Finding includes:The record review for Resident C was completed on 2/4/2026 at 1:19 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), diabetes mellitus type 2, atrial fibrillation and congestive heart failure.A Quarterly Minimum Data Set (MDS) assessment, dated 11/28/2025, indicated Resident C was cognitively intact, required substantial assistance for toileting hygiene and had an indwelling urinary catheter.A Physician's Order, dated 12/16/2025, indicated the supplement potassium chloride crystals extended-release tablet 20 milliequivalents one tablet daily was to be given for hypokalemia. This order decreased the previous order of two tablets dailyA Nursing Progress Note, on 12/23/2025 at 3:38 P.M., indicated Resident C had been refusing to eat or drink and there was a concern for dehydration. A new order for laboratory work had been obtained.A Physician's Order, dated 12/23/2025, indicated laboratory work for a complete blood count with differential, a comprehensive metabolic panel and a b-peptide natriuretic peptide for heart failure and follow-up of heart failure, follow up of leukocytosis and to rule out significant dehydration.A Nurse Practitioner Encounter Note, on 12/26/2025 at 1:00 A.M., indicated a Telehealth visit had occurred due to Resident C's increased confusion. The note indicated Resident C had been reported by a Certified Nursing Assistant (CNA) to have been hard to awaken and Resident C's eyes had rolled. The nurse on shift reported Resident C had been hard to wake up. However, Resident C was back to her baseline during the examination and no longer seemed drowsy. The note indicated that it had been possible that Resident C had been woken from a sleep and had been hard to wake up from his sleep. The nurse had reported a decreased urinary output and an order for a urinalysis test and an order to push oral fluids was placed. A Physician's Order, dated 12/26/2025, indicted to obtain a urinalysis with reflux and culture STAT (immediately) for decreased urinary output.A Nursing Progress Note, on 12/27/2025 at 5:17 A.M., indicated a urinalysis specimen had been obtained at 4:30 A.M. and placed in the refrigerator on the 100 hall (awaiting laboratory services pick up)A Skilled Nursing Assessment, on 1/1/2026 at 12:30 P.M., indicated Resident C was lethargic, but responded to verbal stimuli. In addition, he had swallowing difficulties and had been observed holding food in his mouth/cheeks or residual food in the mouth after meals. All assessments prior to this assessment had documentation of Resident C indicated he was alert and oriented times three (oriented to person, place and time).A Nurse Practitioner Encounter, on 1/2/2026 at 1:00 A.M. and documented as a late entry on 1/2/2026 at 7:18 P.M., indicated Resident C had been seen for a monthly follow-up and chronic disease management. Resident C had been examined in his room and appeared lethargic and barely responsive. Resident C's blood pressure was 82/59 mm/Hg (millimeters per mercury) with a oxygen saturation of 88 percent on room air. Resident C had not responded verbally. It was not clear to the nurse practitioner if this condition was new or a sudden chronic change. An examination of Resident C indicated his mucosal membranes were dry and he had applesauce with medication in his mouth. Resident C was tachypneic, hypoxic with diminished breath sounds. Resident C had been thought to be in acute respiratory failure with hypoxia and referred to the emergency department for emergent diagnostics and treatment.A Skilled Nursing Assessment, on 1/2/2026 at 9:59 A.M., indicated Resident C had been confused and disoriented with edema present.A Nursing Progress Note, on 1/2/2026 at 11:50 A.M., indicated the nurse went to administer medications to Resident C without any concern. Resident C had been observed to be upset and interested to engage verbally with (continued on next page)

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F 0770 Level of Harm - Actual harm Residents Affected - Few	others. The nurse encouraged fluids. The note indicated Resident C had refused his medication around 10:00 A.M. and the nurse had notified the nurse practitioner around 11:00 A.M. that Resident C had been observed to have declined. The nurse and nurse practitioner immediately assessed Resident C. Resident C's blood pressure was 81/61 and oxygen saturations had fluctuated between 88-92 percent and oxygen was applied with the head of the bed elevated. These intervention had been effective. Resident C had been observed to be non-verbal with an increase in altered mental status. Resident C moaned and groaned when moved, but able to move his head with verbal stimuli. Edema had been observed to his bilateral lower extremities, general weakness and difficulty swallowing. 911 was called to transport the resident to the hospital.A Hospital History and Physical, on 1/2/2026 at 4:37 P.M., indicated Resident C had presented to the emergency department earlier today for a decreased level of consciousness. Laboratory results were remarkable for an elevated [NAME] Blood Cell count of 28,000 cells/mcL, a critically elevated potassium level of 7.2 mEq/L, a severely elevated BUN 110 mg/dL and creatinine 3.8 mg/dL level and a urinalysis positive for a urinary tract infection. Diagnoses included, but were not limited to: uremic encephalopathy, acute hypoxic respiratory failure, acute kidney injury, hyperkalemia and pneumonia. Resident C was admitted to the intensive care unit of the acute care facility.During an interview, on 2/5/2026 at 2:20 P.M., the Director of Nursing indicated the ordered laboratory work had not been entered into the laboratory portal to be drawn. She indicated the urinalysis had been collected, but was never picked up by the laboratory. She indicated the laboratory tests that were ordered should have been completed.A policy was provided, on 2/6/2026 at 11:54 A.M., by the Regional Director of Clinical Services. A current policy titled, Laboratory and Radiological Services and Results Reporting, indicated, .The purpose of this policy is to provide guidance for reporting of results from laboratory, radiology, and other diagnostic services to the ordering practitioner. The facility is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource. There are clinical and psychological risks when laboratory, radiology, or other diagnostic services are not performed in a timely manner or the results of these services are not reported and acted upon quickly. Delays may adversely affect a resident's diagnosis, treatment, assessment, and intervention.This citation relates to Intake 27135783.1-49(a)