

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2026
NAME OF PROVIDER OR SUPPLIER Northview Health and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W Cross St Anderson, IN 46011	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure residents received care in a respectful and dignified manner for 1 of 4 residents reviewed for resident rights. (Residents B and D) Findings include:1. Resident B's clinical record was reviewed on 6/22/26 at 12:00 p.m. Diagnoses included left hip osteoarthritis and cerebral infarction without residual effects.A quarterly Minimal Data Set (MDS) assessment, dated 6/16/26, indicated the resident was impaired in both lower extremities; required substantial to maximum assistance for toilet hygiene, toilet transfers, dressing upper and lower body. The resident was moderately cognitively impaired.During an interview on 6/22/26 at 12:37 p.m., Resident B indicated, on the evening of 6/19/26, CNA 1 was assisting her off the toilet. The resident indicated she had a system for transferring from the toilet to her wheelchair. The resident requested to have the wheelchair positioned in a specific position. CNA 1 did not position the wheelchair as requested and repeatedly asked the resident if she needed her assistance. The resident indicated she was beginning to experience pain from sitting on the toilet, became upset and turned the call light on to request someone else to come to assist her. CNA 1 then turned the call light off and took the call light away from the resident. The resident indicated she felt like the CNA was attempting to make her beg for assistance. The resident became frustrated and attempted to get into the wheelchair and fell into the wheelchair. CNA 1 took the resident back to her bed and wanted to pick the resident up and put her into the bed. The resident told her no. The resident threw herself back into bed. The resident told CNA 1 she was going to report her for the way she had treated her and did not want the CNA to provide her care any longer. Resident B indicated she was afraid of CNA 1 and did not want her to return to her room. The resident indicated she reported the incident to an unidentified staff member when her evening meal tray was brought to her. During the interview, the resident became tearful.During an interview, on 6/22/26 at 12:55 p.m., CNA 2 indicated, on the morning of 6/20/26, Resident B was crying and complained about how CNA 1 had treated her the previous evening. The resident asked CNA 2 to call the resident's family member.During an interview, on 6/22/26 at 1:15 p.m., Resident B's family member indicated, on the morning of 6/20/26, the resident called her and indicated she was very upset related to an incident that had happened the night before. Resident B told her CNA 1 tried to make her beg to get off the toilet.2. Resident D's clinical record was reviewed on 6/23/26 at 11:38 a.m. Diagnoses included cerebral infarction and legal blindness.A significant change MDS assessment, dated 4/7/26, indicated the resident required supervision/touch assistance for eating and dependent for all other activities of daily living. The resident was cognitively intact.During an interview, on 6/22/26 at 12:54 p.m., Resident D indicated, on 6/19/25 during the evening meal, CNA 1 came into their room to assist her with the meal. The resident indicated she was blind, but she liked to feed herself when she could. The resident always requested a towel to cover her chest so she would not get messy while eating. CNA 1 told the resident she would clean her up if she got messy and did not honor her request for the towel. The resident also indicated she and her roommate liked to keep the privacy curtain open unless they were receiving personal care, such as changing clothing. CNA 1 repeatedly closed the curtain even after they requested it to remain open. The resident indicated she did not want to receive care from CNA 1 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the future. During an interview on 6/22/26 at 12:55 p.m., CNA 2 indicated Resident D required assistance with meals and always requested a towel to cover her chest during meals. CNA 2 indicated that both Resident D and her roommate had complained to her about how they were treated by CNA 1. During an interview, on 6/23/26 at 9:06 a.m., LPN 7 indicated, on 6/19/26 at approximately 5:00 p.m., she entered Resident B's room. The resident was tearful and appeared to be upset. The resident indicated CNA 1 had mistreated her. LPN 7 called the Administrator. The Administrator returned to the facility and spoke with the resident. LPN 7 heard yelling coming from another resident room and investigated. Resident D and her roommate were upset about how Resident D was treated by CNA 1. Resident D had requested a towel to cover her chest while she was eating, and CNA 1 did not provide the towel. CNA 1 was unavailable for interview during the survey. A current facility policy, dated 5/9/23 and last revised 10/24, titled Abuse, Neglect and Exploitation was provided by the DON on 6/22/26 at 12:41 p.m. The policy indicated the following: .Policy: It is the policy of this facility to provide protection s for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. This citation relates to Intake 3050008.410 Indiana Administrative Code 3.1-27(a)(3)		