STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northview Health and Living	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 0600 Level of Harm - 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. Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from verbal abuse from staff for 1 of 3 residents reviewed for abuse, as evidenced by CNA 3 placing soap and/or hot sauce in the resident's mouth and expressing threats of washing the resident's mouth out with soap. (Resident B) Using the reasonable person concept, it can be determined that Resident B experienced psychosocial harm from these abusive actions and threats of corporal punishment taking place in her home (the nursing facility). Findings include: During a confidential interview, one of Resident B's representatives indicated they had been contacted by the facility regarding an allegation of Resident B being abused by an employee. They were informed a staff member put either soap, hot sauce, or both on their loved one's mouth (Resident B). Their loved one was cognitively impaired. Resident B did not remember the event. Prior to her cognitive impairment, she would have considered soap or hot sauce in the mouth to be abusive. She might have believed she had done something wrong and was being punished. In her day, she may have thought some people put soap in a child's mouth for lying or cursing. Resident B probably believed she was being punished. During an interview on 3/2/26 at 2:28 p.m., LPN 4 indicated she did not remember the time, but the event occurred after supper (around 6:40 p.m.) on 1/26/26. She heard Resident B ask for water and she was given water. At this time, she first heard rumors or gossip about CNA 3 giving, or threatening to give, Resident B hot sauce and /or soap. She asked the nursing staff to figure out what was going on and she went on break. She did not remove CNA 3 from providing patient care. The gossip or rumors felt odd, and she thought the Administrator should be aware. She notified her at about 9:40 p.m. She should have notified the Administrator immediately when she heard gossip of or a rumor of abuse.During an interview on 3/2/26 at 2:22 p.m. CNA 7 indicated she did not see anything on the night of 1/26/26. She did hear CNA 3 say the words wash your mouth out with soap or something like that. She saw CNA 3 with soap, water, and a toothbrush. CNA 5 told her that CNA 3 had been talking about putting hot sauce in Resident B's mouth. She believed LPN 4 and LPN 6 were aware of all that was happening and were taking care of it. She should have reported to the Administrator as soon as she heard of an allegation of abuse.During an interview on 3/2/26 at 1:53 p.m., the Administrator indicated she was notified on 1/26/26 at approximately 10:00 p.m. that CNA 3 may have put hot sauce and/or soap in Resident B's mouth and may have threatened to wash her mouth out with soap. When she was called, she had been asleep. She woke up when they called her and was somewhat confused, therefore she didn't report the allegation to the IDOH until 1/27/26. She should have reported the allegation to IDOH sooner. She did not realize she needed to give a detailed report of the allegation when reporting to the state. She had called the non-emergency police to report the allegation, but they hadn't called her back. She instructed LPN 4 when she called to remove CNA 3 from the floor and send her home pending investigation. The time lapse from the event until staff notified her resulted in CNA 3 working on the floor with resident contact for approximately three hours after staff first became aware of an allegation of abuse. Review of a facility security video with the Administrator present, on 3/2/26 at 3:15 p.m., indicated the following: The time stamp at the top of the video indicated 1/26/26 at 6:31 p.m. Resident B was seated in a wheelchair in the lounge facing (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	the hallway and the nurse's station. CNA 3 walked by the resident several times and spoke to her on multiple occasions. The resident spit on the floor at least two times. (The video had no sound, and the conversation could not be heard.) At 6:58 p.m., CNA 3 entered the frame standing at a cart across from where the resident was seated. The CNA was carrying a cup, a toothbrush, and a white squeeze bottle container. The CNA wet the brush and distributed some liquid from the white squeeze bottle on the toothbrush. She then approached the resident carrying all three items. She held the toothbrush towards the resident. Her stance then blocked the view of the camera. She could be seen moving her arm back and forth. She then turned and walked back toward the cart or counter. She sat all items on the counter. She picked up the squeeze bottle and walked back to the resident. Once again, she stood in a manner that all activity was not visible. She turned the bottle upside down and appeared to squeeze out liquid on the resident's hand or finger. She then turned and walked back to the counter and collected all items and walked away. The resident spit toward the floor after this encounter.During an observation on 3/3/26 at 10:28 a.m., accompanied by the Administrator, the supply cabinet was observed. The cabinet contained a small white squirt bottle of soap, consistent with the bottle seen on the video. A Facility Self-Reported Incident, submitted to the Indiana Department of Health (IDOH) on 1/27/26, indicated the following: The staff overheard CNA 3 make inappropriate comments to Resident B and intervened and directed the CNA to cease interaction with resident. The employee was removed from schedule pending investigation. The nurse practitioner (NP), Director of Nursing (DON), Administrator, and family were notified. The witnessing staff was identified as LPN 4.Review of the facility investigation, provided by the Administrator on 3/2/26 at 4:08 p.m., indicated the following:A (misdated), 1/25/26, written statement (event occurred 1/26/26), indicated LPN 4 overheard rumors of concern on 1/26/26 after the evening meal. She told staff to figure out what was going on. CNA 3 remained on the floor, interacting with residents. LPN 4 went on break. She came back from break and asked some questions and investigated the rumors and reported the allegation to the Administrator at 9:40 p.m. At this time, she reported (9:40 p.m.) LPN 4 was informed to send CNA 3 home pending investigation. CNA 3 had remained on the floor approximately three hours after the time this nurse became aware of the allegations. CNA 5's, 1/26/26, written statement indicated she witnessed CNA 3 take a red packet from a cart or drawer and put it in Resident B's mouth. CNA 3 told her she had put hot sauce in the resident's mouth for spitting. She heard CNA 3 threatened to wash the resident's mouth out with soap for spitting. She later saw the CNA with soap. She did not report her concerns to anyone. A 1/27/26, written statement from LPN 6 indicated she heard CNA 3 threaten to wash Resident B's mouth out with soap. She told the CNA to stop saying that. She did not intervene, report the threat to the Administrator, or remove CNA 3 from the floor. CNA 3 continued working on the floor until approximately 9:40 p.m., when LPN 4 called the Administrator. CNA 5 was unavailable for interview during the survey dates.CNA 3 was unavailable for interview during the survey dates.LPN 6 was unavailable for interview during the survey dates.Resident B's clinical record was reviewed on 2/26/26 at 3:30 p.m. Current diagnoses included gastroesophageal reflux disease, depression, anxiety, and vascular dementia. A current, 1/11/21, care plan problem/need indicated the resident had depression.A current, 6/9/22, care plan problem/need indicated the resident gastrointestinal upset due to gastroesophageal reflux disease and a history of nausea and vomiting. An approach to this problem was to remind me to avoid foods or beverages that tend to irritate esophageal lining such as alcohol, caffeine, chocolate, acidic or spicy foods.A 2/18/26 Psychiatric Progress Note indicated Resident B required behavioral follow-up for behavioral symptoms associated with dementia. She experienced periods of altered lucidity. She also had a history of delusions. A 1/21/26 Psychiatric Progress Note indicated the resident was seen due to depression and vascular dementia. She was a poor historian due to cognitive/psychiatric impairment. A current, 10/22, facility policy, titled Reporting od Reasonable Suspicion of a Crime: Reporting, Investigating/Preventing/ Correcting Any Alleged Violation , which was provided by the Administrator via email on 3/2/26 at 5:15 p.m. indicated: To also ensure all alleged violations (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	involving abuse, neglect. Exploitation, or mistreatment .are reported immediately.Administrator or designee will notify the appropriate agencies immediately.all employees.obligation to report any suspicion of a crime. A current, 10/22, facility policy, titled Abuse Neglect and Exploitation , which was provided by the Administrator via email on 3/2/26 at 5:15 p.m. indicated: .The resident has the right to be free from mistreatment, neglect.Resident must not be subject to abuse by anyone. Report allegations of suspected abuse, neglect, or exploitation immediately to the Administrator. Other officials in accordance with state law.Physical abuse includes but not limited to.controlling behaviors through corporal punishment. This tag relates to Intake 2727362. 410 IAC (Indiana Administrative Code) 16.2-3.1 - 27(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 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. Based on observation, interview and record review, the facility failed to ensure menus were prepared in advance, signed and approved by a Registered Dietitian, had portion size guidance, and ensured nutritional adequacy. This deficient practice had the potential to impact 72 of 72 residents who ate meals prepared in the facility kitchen.Findings include:During an interview on 3/4/26 at 11:09 a.m., the DON indicated when the survey began the facility had a census of 74. Of the 74 residents, 72 consumed food by mouth and ate meals prepared in the facility kitchen.During an observation of the puree process, on 3/2/26 at 10:33 a.m., [NAME] 11 began to puree the entree of baked potato bar or topped baked potatoes. He had a steam table pan with peeled baked potatoes. The potatoes had flecks of orange and brown on them. During an interview, at the time of the observation, [NAME] 11 indicated the orange flecks were cheese and the brown flecks were bacon. He indicated he did not measure the cheese or bacon to ensure each resident received an adequate amount of protein. He indicated he sprinkled some cheese and bacon on top of the pan with 10 potatoes. He then demonstrated an amount of less than 1/2 cup cheese and 1/4 cup bacon for the entire pan of potatoes. He indicated he did not have a recipe, menu, or portion size guidance for the baked potato entree. While he pureed the food, he added tap water from the sink as a thinning liquid. He did not add a liquid which contained nutritive value. He indicated he would serve the same portion size of potatoes as were served when baked potatoes were a side dish.During an interview, on 3/2/26 at 10:40 a.m., the Dietary Manager indicated the facility did not have a menu, a recipe, or portion sized guidance for the potato bar meal. She additionally indicated the RD (Registered Dietitian) had not approved the menu being served. The menu had changed to offer more variety, and the residents liked the potatoes. She did not know how much cheese, bacon, sour cream, and butter pats should be served to equal the protein needed for the meal. There was no other source of protein served to balance the resident's needs. Even though the RD had not reviewed and approved the menu, she was preparing to serve the item as listed on the Menu document. She indicated the cook should have used liquid canned cheese sauce instead of shredded cheese. Unless a resident chose an alternate food item, every diet type was to receive a topped baked potato. During an observation at this time, the canned queso cheese she had planned to use to top the potatoes was noted to have a label which indicated there was zero protein per serving. During an interview on 3/3/26 at 1:25 p.m., the RD indicated she had not developed the menu for the potato bar/topped potato entree, nor approved the menu for the meal before food preparation was begun on 3/2/26. An untitled, undated, facility document was provided via email by the Administrator on 3/2/26 at 11:40 a.m., following the observation and interview regarding protein, indicating the facility had then requested a review of the topped baked potato meal to be served on 3/2/26. The RD added two ounces of ham as protein to ensure nutritional adequacy.An untitled and undated facility document was provided via email by the Administrator on 2/25/26 at 9:07 a.m., and indicated lunch on Monday, 3/2/26, was menued to be baked potato bar, broccoli, cheese sauce, sour cream, bacon bits, Mandarin oranges, chives, and margarine. No additional protein was listed. The menu was not signed as approved by the RD.A current, 5/5/25, facility policy titled Menus and Adequate Nutrition, was provided by the Administrator via email on 3/3/26 at 3:06 p.m., and indicated the following: .The facility will ensure that menus meet the nutritional needs of the resident in accordance with established national guidelines. 8. The facility's dietitian or other clinically qualified nutrition professional will review all menus for nutritional adequacy and approve the menus. 410 IAC (Indiana Administrative Code) 16.2-3.1 - (20)(i)(1)410 IAC 16.2-3.1 - (20)(i)(3)410 IAC 16.2-3.1 - (20)(i)(4)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review, the facility failed to ensure staff reported allegations of abuse immediately to the Administrator or designee and failed to ensure self-reported incidents were communicated to the Indiana Department of Health in a manner that was accurate, detailed, complete, and thorough to allow the department to evaluate the need to advocate for the health and safety of the facility residents for 1 of 3 self- reported incidents reviewed. (Resident B) Findings include:Findings include: A Facility Self-Reported Incident, submitted to the Indiana Department of Health (IDOH) on 1/27/26, indicated the following: The staff overheard CNA 3 make inappropriate comments to Resident B and intervened and directed the CNA to cease interaction with resident. The employee was removed from schedule pending investigation. The nurse practitioner (NP), Director of Nursing (DON), Administrator, and family were notified. The witnessing staff was identified as LPN 4.During a confidential interview, one of Resident B's representatives indicated they had been contacted by the facility regarding an allegation of Resident B being abused by an employee. They were informed a staff member put either soap, hot sauce, or both on their loved one's mouth (Resident B). Their loved one was cognitively impaired. Resident B did not remember the event. Prior to her cognitive impairment, she would have considered soap or hot sauce in the mouth to be abusive. She might have believed she had done something wrong and was being punished. In her day, she may have thought some people put soap in a child's mouth for lying or cursing. Resident B probably believed she was being punished. Neither the original incident report, nor the five day follow up, indicated the resident had been threatened by the staff member or that there was an allegation of placing soap and/or hot sauce in the resident's mouth.During an interview on 3/2/26 at 2:28 p.m., LPN 4 indicated she did not remember the time, but the event occurred after supper (around 6:40 p.m.) on 1/26/26. She heard Resident B ask for water and she was given water. At this time, she first heard rumors or gossip about CNA 3 giving, or threatening to give, Resident B hot sauce and /or soap. The gossip or rumors felt odd, and she thought the Administrator should be aware. She notified her at about 9:40 p.m. She should have notified the Administrator immediately when she heard gossip of or a rumor of abuse.During an interview on 3/2/26 at 2:22 p.m. CNA 7 indicated she did not see anything on the night of 1/26/26. She did hear CNA 3 say the words wash your mouth out with soap or something like that. She saw CNA 3 with soap, water, and a toothbrush. CNA 5 told her that CNA 3 had been talking about putting hot sauce in Resident B's mouth. She believed LPN 4 and LPN 6 were aware of all that was happening and were taking care of it. She should have reported to the Administrator as soon as she heard of an allegation of abuse.During an interview on 3/2/26 at 1:53 p.m., the Administrator indicated she was notified on 1/26/26 at approximately 10:00 p.m. that CNA 3 may have put hot sauce and/or soap in Resident B's mouth and may have threatened to wash her mouth out with soap. When she was called, she had been asleep. She woke up when they called her and was somewhat confused, therefore she didn't report the allegation to the IDOH until 1/27/26. She should have reported the allegation to IDOH sooner. She did not realize she needed to give a detailed report of the allegation when reporting to the state. CNA 5 was unavailable for interview during the survey dates.CNA 3 was unavailable for interview during the survey dates.LPN 6 was unavailable for interview during the survey dates.Resident B's clinical record was reviewed on 2/26/26 at 3:30 p.m. Current diagnoses included gastroesophageal reflux disease, depression, anxiety, and vascular dementia. A current, 10/22, facility policy, titled Reporting of Reasonable Suspicion of a Crime: Reporting, Investigating/Preventing/ Correcting Any Alleged Violation , provided by the Administrator via email on 3/2/26 at 5:15 p.m., indicated: To also ensure all alleged violations involving abuse, neglect. Exploitation, or mistreatment .are reported immediately.Administrator or designee will notify the appropriate agencies immediately.all employees.obligation to report any suspicion of a crime. A current, 10/22, facility policy, titled Abuse Neglect and Exploitation , provided by the Administrator (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	via email on 3/2/26 at 5:15 p.m. indicated: .The resident has the right to be free from mistreatment, neglect.Resident must not be subject to abuse by anyone. Report allegations of suspected abuse, neglect, or exploitation immediately to the Administrator. Other officials in accordance with state law.Physical abuse includes but not limited to.controlling behaviors through corporal punishment. Cross reference F600. This tag relates to Intake 2727362. 410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to protect residents from the potential for further abuse when an alleged perpetrator (CNA 3) was permitted to continue providing care to residents for approximately three hours following an allegation of abuse. (Resident B)Findings include: Findings include: During a confidential interview, one of Resident B's representatives indicated they had been contacted by the facility regarding an allegation of Resident B being abused by an employee. They were informed a staff member put either soap, hot sauce, or both on their loved one's mouth (Resident B). Their loved one was cognitively impaired. Resident B did not remember the event. Prior to her cognitive impairment, she would have considered soap or hot sauce in the mouth to be abusive. She might have believed she had done something wrong and was being punished. In her day, she may have thought some people put soap in a child's mouth for lying or cursing. Resident B probably believed she was being punished. During an interview on 3/2/26 at 2:28 p.m., LPN 4 indicated she did not remember the time, but the event occurred after supper (around 6:40 p.m.) on 1/26/26. She heard Resident B ask for water and she was given water. At this time, she first heard rumors or gossip about CNA 3 giving, or threatening to give, Resident B hot sauce and /or soap. She asked the nursing staff to figure out what was going on and she went on break. She did not remove CNA 3 from providing patient care. The gossip or rumors felt odd, and she thought the Administrator should be aware. She notified her at about 9:40 p.m. She should have notified the Administrator immediately when she heard gossip of or a rumor of abuse.During an interview on 3/2/26 at 2:22 p.m. CNA 7 indicated she did not see anything on the night of 1/26/26. She did hear CNA 3 say the words wash your mouth out with soap or something like that. She saw CNA 3 with soap, water, and a toothbrush. CNA 5 told her that CNA 3 had been talking about putting hot sauce in Resident B's mouth. She believed LPN 4 and LPN 6 were aware of all that was happening and were taking care of it. She should have reported to the Administrator as soon as she heard of an allegation of abuse.During an interview on 3/2/26 at 1:53 p.m., the Administrator indicated she was notified on 1/26/26 at approximately 10:00 p.m. that CNA 3 may have put hot sauce and/or soap in Resident B's mouth and may have threatened to wash her mouth out with soap. She instructed LPN 4 when she called to remove CNA 3 from the floor and send her home pending investigation. The time lapse from the event until staff notified her resulted in CNA 3 working on the floor with resident contact for approximately three hours after staff first became aware of an allegation of abuse. Review of the facility investigation, provided by the Administrator on 3/2/26 at 4:08 p.m., indicated the following:A (misdated), 1/25/26, written statement (event occurred 1/26/26), indicated LPN 4 overheard rumors of concern on 1/26/26 after the evening meal. She told staff to figure out what was going on. CNA 3 remained on the floor, interacting with residents. LPN 4 went on break. She came back from break and asked some questions and investigated the rumors and reported the allegation to the Administrator at 9:40 p.m. At this time, she reported (9:40 p.m.) LPN 4 was informed to send CNA 3 home pending investigation. CNA 3 had remained on the floor approximately three hours after the time this nurse became aware of the allegations. CNA 5's, 1/26/26, written statement indicated she witnessed CNA 3 take a red packet from a cart or drawer and put it in Resident B's mouth. CNA 3 told her she had put hot sauce in the resident's mouth for spitting. She heard CNA 3 threatened to wash the resident's mouth out with soap for spitting. She later saw the CNA with soap. She did not report her concerns to anyone. A 1/27/26, written statement from LPN 6 indicated she heard CNA 3 threaten to wash Resident B's mouth out with soap. She told the CNA to stop saying that. She did not intervene, report the threat to the Administrator, or remove CNA 3 from the floor. CNA 3 continued working on the floor until approximately 9:40 p.m., when LPN 4 called the Administrator. CNA 5 was unavailable for interview during the survey dates.CNA 3 was unavailable for interview during the survey dates.LPN 6 was unavailable for interview during the survey dates.Resident B's clinical record was reviewed on 2/26/26 at 3:30 p.m. Current diagnoses included gastroesophageal reflux disease, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depression, anxiety, and vascular dementia. A current, 1/11/21, care plan problem/need indicated the resident had depression.A current, 10/22, facility policy, titled Reporting of Reasonable Suspicion of a Crime: Reporting, Investigating/Preventing/ Correcting Any Alleged Violation, provided by the Administrator via email on 3/2/26 at 5:15 p.m. indicated: To also ensure all alleged violations involving abuse, neglect. Exploitation, or mistreatment .are reported immediately.Administrator or designee will notify the appropriate agencies immediately.all employees.obligation to report any suspicion of a crime. A current, 10/22, facility policy, titled Abuse Neglect and Exploitation, provided by the Administrator via email on 3/2/26 at 5:15 p.m. indicated: .The resident has the right to be free from mistreatment, neglect.Resident must not be subject to abuse by anyone. Report allegations of suspected abuse, neglect, or exploitation immediately to the Administrator. Other officials in accordance with state law.Physical abuse includes but not limited to.controlling behaviors through corporal punishment. Cross reference F600.Cross reference F609.This tag relates to Intake 2727362.410 IAC (Indiana Administrative Code) 16.2-3.1-28(d)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide residents and/or their representatives with written notice of transfer/discharge and bed hold policy for 3 of 4 residents reviewed for hospitalizations. (Residents 77, 69, and 7)Finding includes: 1.Resident 7's clinical record was reviewed on 3/2/26 at 10:18 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), Parkinson's disease, and hypertension. A 1/23/26, discharge MDS assessment indicated the resident discharged with a return anticipated. A 1/23/26, progress note indicated Resident 7 complained of pain in the left knee and hip related to a previous fall. A new order to send the resident to the emergency room was obtained. The clinical record lacked indication the resident and/or representative was provided with a copy of the transfer/discharge form and bed hold policy. Review of notice of transfer/discharge forms and bed hold policy, dated 1/23/26, provided by the RN Clinical Support on 3/3/26 at 3:49 p.m., indicated the resident was discharged to the hospital. The documents did not indicate the resident or resident's representative were provided with the notices. The forms lacked documentation regarding who received the paperwork. 2.Resident 69's clinical record was reviewed on 3/2/26 at 1:20 p.m. Diagnoses included right sided hemiplegia (paralysis) and hemiparesis (weakness). A 9/23/25, progress note indicated Resident 69 was unable to follow commands, unable to speak, or track with his eyes. A new order to send the resident to the emergency room was obtained. A 10/2/25, progress note indicated Resident 69 was unable to answer questions correctly. A new order to send the resident to the emergency room was obtained. A 12/25/25, progress note indicated Resident 69 had altered mental status and the resident's wife requested the emergency room transfer. The clinical record lacked indication the resident and/or representative was provided with a copy of the transfer/discharge form and bed hold policy for any of the transfers. Review of notice of transfer/discharge forms and bed hold policy, dated 12/25/25, 10/2/25, and 9/23/25, provided by the RN Corporate Consultant on 3/3/26 at 3:49 p.m., indicated the resident was discharged to the hospital. The documents did not indicate the resident or resident's representative were provided with the notices. The forms lacked documentation regarding who received the paperwork. 3.Resident 77's record was reviewed on 3/4/26 at 9:56 a.m. Diagnoses included dementia and hypertension. A 12/21/25, progress note indicated the resident was in respiratory distress and was transported to a local hospital by emergency services. The family and administrator were notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northview Health and Living	1235 W Cross St Anderson, IN 46011

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 12/21/25 online e-Interact transfer form lacked notice of discharge or bed hold policy. The clinical record lacked indication the resident and/or representative was provided with a copy of the transfer/discharge form and bed hold policy. During an interview, on 3/3/26 at 3:19 p.m., RN 9 indicated, when sending a resident to the emergency room, she would print out resident specific documents such as the face sheet, orders, and code status. She would ensure the resident specific documents and report were provided to the Emergency Medical Technicians (EMTs). During an interview, on 3/3/26 at 3:23 p.m., LPN 10 indicated when sending a resident to the emergency room she would print out resident specific documents such as the face sheet, orders, progress notes, and code status. She would also provide a copy of the facility bed hold policy. She would ensure the resident specific documents and report were provided to EMTs. During an interview, on 3/3/26 at 3:26 p.m., the DON indicated when a resident was sent to the emergency room, the nurse would complete the online e-Interact form and print out resident specific documents such as the face sheet, medication lists, and provide a copy of the facility bed hold policy. The staff provided these documents to the EMTs to take to the hospital. During an interview, on 3/4/26 at 10:10 a.m., the DON indicated the resident information packet, transfer/discharge form, and bed hold policy should be provided to the resident if they were alert and oriented. If the resident was not alert and oriented, then the facility should contact the resident's representative and give them the transfer/discharge forms and bed hold policy. The staff should document in the clinical record who received these documents. During an interview on 3/4/26 at 11:56 a.m., the DON indicated she was unable to locate Resident 77's transfer/discharge forms and bed hold policy. A current facility policy, titled, Transfer and Discharge (Including AMA), implemented 5/15/25, and provided by the Administrator on 3/4/26 at 11:42 a.m., indicated the following: .3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they understand.4. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident.10 Emergency Transfers to Acute Care.d. The original copies of the transfer form and Advance Directive will accompany the resident. Copies will be retained in the medical record.g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. 410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(A)(i)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure a resident was permitted to exercise their right to determine their own treatment by denying transfer to an emergency room for reported pain. (Resident 69)Findings include:Resident 69's clinical record was reviewed on 3/2/26 at 1:20 p.m. Diagnoses included right sided hemiplegia (paralysis) and hemiparesis (weakness), calculus of kidney (kidney stones), urine retention, and presence of ureteral stents.Current physician orders include oxycodone (a narcotic medication) 5 milligrams (mg) by mouth every 4 hours as needed (PRN) for mild to moderate pain and acetaminophen (an analgesic pain reliever) 500 mg by mouth every 8 hours PRN for pain.A 9/4/25, admission, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.A 10/2/25 at 3:31 a.m., progress note indicated Resident 69 reported back pain and requested his pain medication. The resident's narcotic pain medication had been provided at 12:36 a.m., and another dose was not available yet. The resident's analgesic pain reliever was offered instead. Resident 69 indicated he wanted to go to the hospital for his back pain. The nurse contacted the on-call provider and explained the situation. The resident was unable to provide additional details about the back pain. The on-call provider and nurse reviewed Resident 69's diagnosis to try and determine the cause of the back pain and why he would want to be sent to the emergency room. They could not find any diagnosis that would suggest going to the hospital was appropriate. The on-call provider advised the nurse that they did not send residents to the hospital for just back pain alone. The nurse should monitor him for relief from the acetaminophen and provide his PRN narcotic as soon as available.A 10/2/25 at 4:37 p.m., progress note indicated the resident's lab results returned with elevated white blood cells. Upon entering the resident's room, he could not answer questions correctly. His blood pressure was 165/93 millimeters of mercury (mmHg), and his pulse was 135 beats per minute (bpm). The nurse practitioner (NP) was contacted and an order to send the resident to the emergency room was obtained.A 10/2/25, hospital lab report, provided by the DON on 3/3/26 at 3:49 p.m., indicated the residents' white blood cell count was elevated. The diagnosis attached to the lab report indicated the resident had sepsis (a life-threatening, emergency response to infection) without acute organ dysfunction, due to an unknown organism.A 10/7/25, hospital discharge summary indicated the resident was admitted with acute encephalopathy (broad term for any disease or dysfunction altering brain function) and had pseudomonas aeruginosa (a bacteria) in his urine.During an interview, on 3/3/26 at 3:19 p.m., RN 9 indicated if a resident requested to be sent out to the emergency room for pain, she would contact the physician to obtain an order. If a physician refused to provide an order to send the resident to the emergency room, she would speak with the resident again and see if they still wanted to be sent out. If the resident still wanted to be sent out to the hospital, she should follow the facility procedure to send the resident out as requested. All residents have the right to be sent to the emergency room/ hospital as they requested.During an interview, on 3/3/26 at 3:23 p.m., LPN 10 indicated if a resident requested to be sent out to the hospital or emergency room for pain, she would contact the physician to obtain an order. If the physician refused to send the resident out to the hospital, she would speak with the resident again and suggest alternative interventions and/or medications. If the resident still requested to be sent to the emergency room, she would follow the facility procedure to send the resident out. The residents have the right to request they be sent to the emergency room for evaluation and treatment.During an interview, on 3/3/26 at 3:26 p.m., the DON indicated if a resident requested to be sent to the hospital for pain, the staff would contact the physician and obtain an order to send the resident out. If the physician refused to provide an order to send the resident out, they would re-address the situation with the resident. If the resident still wished to be sent out for evaluation and/or treatment, then the staff would follow the facility procedure to send a resident to the emergency room/hospital. The residents have the right to be sent out to the hospital. The DON indicated she had never had a physician refuse to send a resident to the emergency room. Resident 69 should have been sent out to the hospital (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when he requested this on the morning of 10/2/25.A current undated facility policy, titled, Know Your Rights under Federal Nursing Home Regulations, provided by the RN Corporate Consultant on 3/3/26 at 3:44 p.m., indicated the following: You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility. You have the right to be informed, and participate in, your treatment. This includes the right to: . Participate in the development and implementation of your person-centered plan of care.Be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option you prefer. Request, refuse, and/or discontinue treatment. You have the right to and the facility must promote and facilitate self-determination through support of resident choice, including: The right to choose activities, schedules.healthcare, and providers of health care services consistent with your interest, assessments, plan of care and other applicable provisions of this part.410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)410 IAC (Indiana Administrative Code) 16.2-3.1-3(n)(3)