STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 10, 11, 12, 13, and 14, 2023 Facility number: 000562 Provider number: 155718 AIM number: 100267150 Census Bed Type: SNF/NF: 71 SNF: 4 Total: 75 Census Payor Type: Medicare: 17 Medicaid: 41 Other: 17 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 21, 2023.	F 0000	This Plan of Correction constitutes the written allegation of compliance for deficiencies cited 4/14/2023. The submission of this Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents,			

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

Kim Carlson | HFA | 05/02/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on observation, interview, and record review, the facility failed to respond to, and resolve, resident care concerns regarding dining assistance in a timely manner for 1 of 3 residents reviewed for nutrition. (Resident 8) Finding includes: During an interview, on 4/10/23 at 3:33 p.m., Resident 8 was in bed in her room. She was tearful, and indicated she was blind and needed to be fed her meals. However, the facility would not give her meal assistance. She preferred to have her meals in her room. She felt it took so much for her to get to the dining room because she had to be transferred with a mechanical lift. She had experienced a weight loss since she admitted to the facility. She was probably only getting a fourth of each meal because she dropped her food all over herself when she tried to eat without assistance. At times, she had refused meals because she got frustrated when she got food all over the place. It was necessary for her to use her fingers to eat, as she had trouble using silverware due to her lack of vision. She had made staff aware of her preference of being assisted in her room. They told her she would have to eat in the dining room to receive assistance. She had asked various staff members to feed her and her representative had spoken to management on multiple occasions about staff assistance with her meals, but it was not resolved.	F 0585	F585 (SS D) What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice: The Corrective Action process will ensure grievances will be documented and resolved in a timely manner. Grievances will be logged in a timely and accurate manner. Issues will be forwarded to the appropriate departments for resolution. Grievances will be maintained by social services designee in log system and will be reviewed every weekday morning at IDT meeting. Grievances will be investigated and resolved with documentation. Resident # 8 family was notified of resident's refusal at times for being fed by staff. Audit tool is now used to track assisting the resident with meals. If resident # 8 refuses to be assisted with meals, the family is to be notified. Tracking tool implemented. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective**	05/12/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 8's clinical record was reviewed on 4/11/23 at 2:34 p.m. Diagnoses included, blindness in one eye, low vision in the other eye, anxiety disorder, and major depressive disorder. Current physician orders included Pristiq (depression) extended release 24 hour tablet 50 milligrams (mg) once daily, buspirone (anxiety) hydrochloride 7.5 mg once daily, very high calorie nutritional drink(for weight loss) 237 milliliters (ml) daily, and regular diet with pureed texture with the exception of regular fruit loops, may have pleasure foods that are not pureed. A quarterly Minimum Data Set (MDS) assessment, dated 1/19/23, indicated the resident was cognitively intact. She required extensive assistance for bed mobility, total dependence for toileting and personal hygiene, limited assistance of 1 staff member for eating, and transfers did not occur. A current care plan, revised 11/1/22, indicated the resident received psychotropic medications related to major depressive disorder. Interventions included the following: observe, record, and report refusal to eat, difficulty swallowing, depression, loss of appetite, and weight loss. A current care plan, revised 1/4/22, indicated the resident required a mechanically therapeutically altered diet. Interventions included the following: adaptive equipment - soups in mug with lid (8/24/21), assist with feeding and cueing for meals (1/4/22), and provide supplement as ordered (8/24/21). A current care plan, revised 2/25/22, indicated the		**action will be taken:** Grievances and concerns will be documented and resolved in a timely manner by the appropriate department with resolution discussed with appropriate resident/family. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** Grievances (Attachment 1) will be logged in a timely and accurate manner; each IDT member has copies of the grievance form. Grievance forms are also available outside the social service office for families to use or for staff to use after hours. It is noted to turn the form into social service or under their door after hours. This form will be logged and given to the appropriate department manager for resolution. Log of grievances will be maintained by Social Service Designee and monitored for completeness. Grievance log will be reviewed daily, Monday – Friday at IDT meeting. Grievances will be investigated and resolved with documentation. **How will the corrective action be monitored to ensure the deficient practice will not recur:** Log (Attachment 2) and resolutions will be monitored by Social Service Designee daily and reviewed by administrator weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was at risk for potential alteration of nutrition related to blindness, major depressive disorder, and significant weight loss 9/2022. Interventions included the following: assist for eating and drinking (2/25/22), and honor preferences (2/25/22). Review of the meal assistance task indicated in the time frame from 3/31/23 to 4/13/23, the resident had independently fed herself for four meals and only received supervision for four meals. A Nurse's Note, dated 3/27/23 at 7:44 a.m., indicated the resident's vision was severely impaired. A Dietary Note, dated 4/4/23 at 9:12 p.m., indicated the resident had prior weight loss. During an observation on 4/12/23 at 11:32 a.m., Nurse Aide (NA) 3 placed the resident's lunch tray on her overbed table, in front of her, and removed the lids from the bowls. The resident was not offered any further assistance, and the NA left the room. The resident had her eyes closed and did not eat her meal. During an interview on 4/12/23 at 4:26 p.m., the resident was in bed in her room. She got tearful and indicated staff had not offered any help, and she had not eaten anything for lunch. During an interview on 4/12/23 at 4:35 p.m., CNA 11 indicated she did not regularly work on the 100 unit. She referenced the CNA Assignment Sheets to determine any specific activity of daily living needs for each resident. Review of the current CNA Assignment Sheet indicated it lacked any specific meal assistance		Log and resolutions will be discussed and evaluated at monthly QAPI meeting to determine if any trends. **Date of** Completion:5/15/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	listed for Resident 8. During an observation on 4/13/23 at 8:28 a.m., the resident was in bed, with her breakfast tray in front of her, wearing a soiled clothing protector. Here eyes were open and her hands were on her tray. She had two empty bowls in front of her on the tray, and two untouched bowls behind them. She had a small amount of milk left in one cup. No one had assisted the resident with her breakfast during the observation. During an observation on 4/13/23 at 8:35 a.m., CNA 12 knocked on the door and asked the resident if she was done with her breakfast tray. She did not offer to assist the resident with the two bowls full of food, nor did she ask if she was aware of the remaining food on her tray. During an interview on 4/13/23 at 10:19 a.m., the resident indicated she fed herself her breakfast on this date without assistance. She was unaware who brought her breakfast tray. They told her she would have to feed herself. She had only received a bowl of oatmeal and a bowl of dry fruit loop cereal on her breakfast tray, along with her drink. If other food was on her tray, she was unaware of it. During a continuous meal observation on 4/13/23 from 11:28 a.m. to 12:28 p.m., NA 3 delivered the resident's lunch tray. NA 3 removed the lids from her food, told the resident to start eating her meal, and told her she would be back later to check on her. NA 3 had not described what was on her tray, nor where each item was located on her tray before she exited the resident's room. At 11:34 a.m., the resident's representative entered the room. The resident attempted to find items on her tray to eat and was observed reaching out into the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	air above the meal tray in an attempt to find the food. Her representative gave commands on where to move her hands (such as up, down, left, and right) to locate the items on her lunch tray. She asked her representative what items were on her lunch tray. The representative picked up each bowl on the lunch tray and smelled the food so she could tell the resident what was in each bowl before she ate them. While eating, her clothing protector became soiled. By 11:42 a.m., all of the meal trays on the 100 unit were delivered. No staff returned to the resident's room to assist her with her meal. On 4/13/23 at 12:15 p.m., CNA 8 knocked on the door and asked to pick up the meal trays. No meal assistance was offered at any time during the 4/13/23 lunch observation. During an interview, at the time of observation on 4/13/23 at 11:54 a.m., the resident's representative indicated the resident was 90% blind, and needed staff assistance with her meals. She had spoken with the Administrator on multiple occasions regarding the resident's lack of meal assistance in her room. She had spoken with the Administrator approximately six weeks ago and again one month ago, regarding the resident's lack of meal assistance. She had also brought this to the facility's attention prior to the above mentioned dates. The representative was unable to stand and assist the resident with her meals due to her own medical condition. She had been to the facility during meals and witnessed the resident with a clothing protector on at meals. Food was all over the clothing protector because the resident had not received any meal assistance. No one had contacted her with a response to her concerns regarding any resolution or actions taken to resolve the concerns. During an interview on 4/13/23 at 12:07 p.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident indicated the Administrator had not spoken to her about her lack of meal assistance. Review of the Dietary Order Sheet, located on her lunch tray on 4/14/23, indicated the resident ate in her room and required feeding assistance with breakfast, lunch, and dinner. During an interview on 4/13/23 at 4:30 p.m., CNA 4 indicated she would know if any resident needed meal assistance by referencing the CNA Assignment Sheet for the units. She looked at her CNA Assignment Sheet and it lacked meal assistance information for Resident 8. The resident should have assistance with all of her meals. Any resident or representative's concerns could be reported to any staff member. All concerns were reported to the nurse, and the nurse would handle the concerns with the proper department. The staff members were not required to fill out any specific form for concerns. During an interview on 4/14/23 at 10:39 a.m., Nurse Aide 3 indicated she was not aware the resident required meal assistance with each meal. The CNA Assignment Sheet was the reference tool used to determine if a resident needed assistance. The sheet lacked information that the resident required assistance with her meals. The resident had impaired vision and had asked to be fed. The resident should have been told where the dietary items were on her tray when the meal was delivered. The resident had been open to receive meal assistance when offered. During an interview on 4/14/23 at 11:09 a.m., LPN 2 indicated the resident required meal assistance for all of her meals. During an interview on 4/14/23 at 11:26 a.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator indicated anyone was able to bring a concern to the grievance process. The concerns could be voiced to any staff member. The concerns were then required to be reported to the Administrator or SSD. A concern form was then completed by the Administrator or the SSD and distributed to the proper department. Once it was addressed, a response was given to the person who reported the concern. Though there was not a set timeline, the concerns were usually addressed within 24 to 48 hours. A review of the grievance log on 4/14/23 at 11:35 a.m., lacked any concerns regarding the resident's need for meal assistance. During an interview on 4/14/23 at 11:42 a.m. the Social Services Assistant indicated the resident's representative had reported concerns regarding the resident's lack of meal assistance. A concern form had not been completed. She lacked documentation of follow-up on the concern. During an interview on 4/14/23 at 11:45 a.m., the Social Service Director indicated concern forms were not documented in the grievance log regarding the resident's lack of meal assistance. During an interview on 4/14/23 at 11:53 a.m., the Administrator indicated the resident's representative reported she had concerns on 4/13/23, and approximately a couple of weeks prior, regarding a lack of meal assistance for the resident. The resident was unable to feed herself well due to poor vision. The Administrator had not completed a concern form for the mentioned dates and put the concern through the grievance process. The concern action and resolution response would have been provided to the resident representative if it had been placed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	through the grievance process. A current policy, dated 11/22/16, titled "Resident and Family Grievances," provided by the Social Services Director on 4/14/23 at 12:06 p.m., indicated the following: "...Policy: Residents and their family members may voice grievances to the facility or other entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The facility will make prompt efforts to resolve grievances. Policy Explanation and Compliance Guidelines: ...2. The Grievance Official is responsible for overseeing the grievance process: receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations...." 3.1-7(a)(1) 3.1-7(a)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure residents were invited to care plan meetings for 1 of 1 resident reviewed for care plan participation. (Resident 10) Findings include: During an interview on 4/10/23 at 10:27 a.m., Resident 10 indicated she had not been invited to a care plan meeting in a long time. She used to always attend the meeting, and would attend if invited. Resident 10's clinical record was reviewed on 4/11/23 at 1:58 p.m. Current diagnoses included anxiety, depression, and schizoaffective disorder-bipolar type. A current, 3/15/23, annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and did not reject care during the assessment period. The most current 3/15/23 Interdisciplinary Team	F 0657	**F657 (SS D) What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** Each resident will be invited to their scheduled care plan to discuss their current plan of care. Residents will be informed of goals and interventions for their individual plan of care. Residents have the right to attend or refuse to attend the scheduled care plan meeting. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** All residents will be invited to their care plan meeting to have the knowledge and choice of the plan of care. Each care plan is individually created for them for person centered care. They can	05/12/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(IDT) Note, related to care plan meetings, did not indicate if the resident had been invited and/or chose not to attend. The clinical record lacked any documentation of the resident being invited to her care plan meeting in the last quarter. The most current care plan note to address the resident's invitation to a care plan meeting or refusal to attend, was dated 11/11/20. During an interview on 4/13/23 at 3:46 p.m., the Social Services Assistant indicated the Social Service Director invited every resident to their care plan meeting; however, there was no documentation of said invitation. During an interview on 4/13/23 at 3:53 p.m., the Social Services Director indicated she invited residents personally to care plan meetings, but did not have any documentation of the invitation. She believed social service notes or IDT care plan notes would include the invitation and response. When informed Resident 10's record lacked such documentation, she indicated it must not have been documented. She had no other information to provide regarding invitations to care plan meetings. A current, 11/22/2016, facility policy titled, "Care Planning-Resident Participation", provided by the Administrator on 4/14/23 at 10:38 a.m., indicated the following: "...The facility will inform the resident/resident representative...of his or her rights regarding planning and implementing care... The facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment...The facility will discuss the plan of care with the resident...and		discuss any issues or changes that have occurred or make suggestions to meet their needs. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** Residents will determine if they want to attend care plan meetings when invited by Social Service Designee. They will then sign a document that is presented to them acknowledging the invitation with date and time, acknowledging their desire to attend or not. Residents who are not cognitively able to make the decision to attend or understand the care plan meeting, will have family members or representative invited by mail to attend the care plan meeting. **How will the corrective action be monitored to ensure the deficient practice will not recur:** A tracking system (Attachment 3) is in place to monitor invitation for the residents. This log will be monitored by Social Service daily x 30 days with audit by administrator weekly. The tracking system will be reviewed at the monthly QAPI meeting with IDT. **Date of Completion: 5/15/2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	allow them to see the care plan...The facility will obtain a signature from the resident and/or representative after discussion or viewing of the care plan...." 3.1-35(c)(2)(C)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident who was at risk for falls and had a history of falls, had their individualized fall intervention in place for 1 of 3 residents reviewed for fall prevention. (Resident 49) Findings include: Resident 49's clinical record was reviewed on 4/11/23 at 2:43 p.m. Current diagnoses included dementia, anxiety, Parkinson's Disease, and repeated falls. The resident had a current, 9/30/22, physician's order for a bed alarm, check functioning and placement each shift and a current, 9/30/22, physician's order for a chair alarm, check placement every shift. A current, 3/31/23, quarterly, Minimum Date Set	F 0689	**F689 (SS D) What Corrective Action will be accomplished for those residents found to have been affected by this deficient Practice:** This deficient practice, as identified in the 2567, was immediately addressed when brought to the attention of the DON and ADON, and a sensor pad was placed, and the pull tab/clip alarm removed. No other residents were affected by this deficient practice. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:** An audit was completed to ensure	05/12/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(MDS) assessment indicated the resident was severely cognitively impaired, displayed no maladaptive behaviors during the assessment period, required staff assistance to transfer from one seated position to another, was totally dependent on staff assistance for purposeful locomotion, used a wheelchair for mobility, used a chair alarm daily, and could only stabilize when standing if she had assistance from staff. A current care plan problem/need, which originated 1/23/23, indicated "I have had falls (enter dates of each fall below) 1/21/23, 2/19/23 witnessed fall, 3/01/23." Approaches to this problem included, "change alarm to a sensory alarm. Date initiated: 3/2/23." A current care plan problem/need, which originated 10/3/22, indicated the resident had Parkinson's Disease. An approach to this problem included, "Monitor for risk of falls. Date initiated: 10/3/22." A current care plan problem/need, which originated 9/30/22, indicated the resident was at risk for falls. An approach to this problem included, "Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter or remove any potential causes if possible. Date initiated: 9/30/22." A 2/19/23 at 3:15 p.m., "Occurrence Note" indicated the root cause of the occurrence was the resident was wandering and became stuck on furniture in the lounge before self-transferring to the floor. A 2/19/23 at 9:38 p.m., "Occurrence Note" indicated the cord to the chair alarm had been		that those residents who had alarms ordered had the correct alarm in place with no other issues found. (Attachment 5) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur:** Education was provided to all Nursing staff during the "All Staff Meeting" regarding the placement of alarms as ordered by the physician. This education included making sure that the alarm ordered was the alarm put in place. Education also included notifying the DON or designee that alarm was ordered. The DON or Designee will follow up the next morning during normal business hours. **How will the corrective action be monitored to ensure the deficient practice will not recur:** To ensure that the alarm ordered per the Physician, is the alarm put in place, the nurse will audit for accurate alarm placement q shift x' 2 weeks, then q shift 3 times weekly x's 2 weeks, then q shift weekly x's 2 weeks. If accurate placement is noted every shift x's 6 weeks, then this audit will be taken to QAPI for review/ discontinuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shortened to prevent a recurrence of falls. The root cause of the occurrence was the resident was confused and attempted to self-transfer. They had poor safety awareness and the cord on the chair alarm was too long. A 3/1/23 at 1:30 p.m., IDT (Inter Disciplinary Team) Note indicated the resident attempted to self transfer to the couch. The alarm was not sounding. The resident alarm was replaced with a sensory alarm. A 3/1/23 at 1:30 p.m., "Occurrence Note" indicated an unwitnessed fall with an alarm in place, but not working. The resident was found near a couch in the lounge on the floor. At this time, the alarm was changed in their wheelchair to a sensor alarm. A 3/1/23, current "Morse Fall Risk Assessment", indicated the resident was at high risk for falls and needed "Implement High Risk Fall prevent interventions." The clinical record lacked an order for a sensor alarm to the resident's Broda chair/wheel chair. Resident 49 was observed in her wheelchair with a clip alarm, as opposed to a sensor alarm, as follows: On 4/10/23 at 11:45 a.m., the resident was seated on a Broda chair (a specialized high back wheelchair) in the lounge. She had a clip alarm attached by a string/cord to the resident's top. On 4/11/23 at 9:13 a.m., the resident was in the lounge. The resident was seated on a Broda chair with a clip alarm attached to her shirt.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/11/23 at 9:32 a.m., the resident was in the lounge. The resident was seated on a Broda chair with a clip alarm attached to her shirt. On 4/12/23 at 10:10 a.m., the resident was in the lounge seated in a Broda chair with a clip alarm attached to the back of her shirt via a string. She periodically leaned very far forward pulling the string very taut. On 4/12/23 at 10:16 a.m., the resident bent over far forward to look in the cabinet under the TV. The alarm was pulled very tightly. Her thighs were far forward off of the Broda chair. On 4/12/23 at 10:18 a.m., the residents remained in front of the TV. Her chair was parallel with the TV stand touching the TV stand. Her clip chair alarm sounded. Unidentified staff arrived promptly. They adjusted the resident's seating and placed her farther back in her chair, with her back against the chair back. The staff member did not assist the resident in moving her Broda chair to an area where she could move freely. On 4/12/23 from 10:27 a.m. to 10:36 a.m., the resident remained in front of the TV stand. She moved back and forth and rocked in her Broda chair. She often appeared to be caught up on the handle of the cabinet. She rocked, moved a few inches back and forth, and bent over far forward, pulling the clip alarm string very tight. On 4/12/23 at 10:36 a.m., the resident appeared to the caught on the handle of the TV stand/cabinet. She kept trying to move. She would move backwards hitting the handle of the Broda chair on the wall then forward dragging the side of the chair against the handle. She eventually got to the side of the cabinet and turned half facing the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wall. She appeared unable to move freely. She sat the the side of her chair making contact with the TV stand, rocking her chair back and forth. On 4/12/23 at 10:38 a.m., a staff member wheeled another resident in the lounge and seated the residents close to Resident 49. Resident 49 sat 3/4 of the way facing the wall, with the side of her chair against the TV stand. She was moving back and forth, approximately three inches, back and forth repeatedly. The staff member did not interact with Resident 49 in any manner, nor assist her to move freely when she appeared unable to move herself. On 4/12/23 at 10:43 a.m., the resident was now almost totally facing the wall and approximately one inch from the wall. A staff member entered the lounge to to help another resident. She looked at Resident 49 and stated, "what you doing honey?" She offered no assistance to Resident 49 after asking the question, and left the area. On 4/12/23 at 10:48 a.m., the resident worked her Broda chair backwards and was no longer facing the wall with her chair against the stand. She was once again in front of the TV and parallel to the stand. She rocked and moved with her chair against the front of the stand and against the handle once more. On 4/12/23 at 10:54 a.m., the resident was in front of the TV alternating between rocking and bending far forward. She did not appear to be able to move her chair at this time. On 4/12/23 from 10:54 a.m. to 11:05 a.m., the resident moved restlessly in front of TV. She rocked and bent far forward.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/12/23 at 11:05 a.m., a staff member entered the lounge, and helped another resident. Resident 49 was still in front of TV restlessly moving, bending and rocking. The staff member offered Resident 49 no assistance. On 4/12/23 at 11:08 a.m., a staff member entered the lounge and wheeled the resident away from TV cabinet and assisted her to face the TV. At this time, the resident was leaning far forward and the alarm clip cord was pulled very tight. The staff member then assisted and encouraged her to lean farther back in her chair. The assistance was offered 40 minutes (10:18 a.m.) after her alarm sounded and she was assisted to lean back in her chair, however was not assisted to relocate the an area where she could move freely. On 4/12/23 at 11:16 a.m.., the resident was facing the TV. She leaned far forward, causing the cord of the clip alarm to be pulled tight. She leaned back and the tension reduced on the cord at 11:21 a.m. On 4/13/23, from 9:00 a.m. to 9:37 a.m., the resident was seated in the lounge in a Broda chair with a clip alarm attached to her top. On 4/13/23 at 3:31 p.m., the resident was seated in her Broda chair in the lounge with a clip alarm attached to her top. On 4/14/23 from 9:27 a.m. to 10:16 a.m., the resident was seated in the lounge in her Broda chair with a clip alarm attached to her top. During an interview on 4/12/23 at 1:48 p.m., NA 3 and CNA 10 indicated they reference the "CNA Care Guide" to know what assistance and protective devices a resident required for safety			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and mobility. Review of an untitled and undated document, provided by NA 3 and CNA 10 on 4/12/23 at 1:48 p.m., indicated Resident 49 used a wheelchair and required a "pressure [sensor] alarm bed and chair..." During an interview on 4/13/23 at 3:41 p.m., CNA 4 indicated Resident 49 was wearing a clip style alarm. During an observation and interview on 4/14/23 at 9:37 a.m., LPN 2 indicated Resident 49 had a clip alarm attached by a cord and clipped to her top. She also had the cord for a sensor alarm attached to her chair, however there was no alarm box attached. During an interview on 4/14/23 at 10:57 a.m., both the DON and ADON indicated Resident 49 should have a sensor alarm when she was seated in her Broda chair. The sensor alarm was care planned and identified by the Interdisciplinary Team as a fall prevention intervention. If Resident 49 or any other resident appeared to be caught on furniture, the resident should be assisted to move. Staff should monitor the resident's location and movements to reduce fall risks. All new interventions should have orders, if indicated, and be put on the CNA Care Guide to ensure proper devices were in place. A current, 7/22/21, facility policy titled, "Fall policy and procedure", provided by the Administrator on 4/14/23 at 110:08 a.m., indicated the following: "...The Nurse and the immediate staff on the unit will do a post fall huddle...to determine the root cause of the fall and an intervention will be put in place. The information			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHVIEW HEALTH AND LIVING	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	will be placed on the 24-hour report, the 'CNA Care Guide' and the EMR [electronic medical record] in risk management, the Occurrence note...." 3.1-45(a)			