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 _____	R 05/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 4/14/23. This visit was in conjunction with a PSR to the Investigation of Complaint IN00404640 completed on 4/3/23. This visit was in conjunction with a PSR to the Investigation of Complaint IN00406982 completed on 4/27/23. Complaint IN00404640 - Corrected. Complaint IN00406982 - Corrected. Survey dates: May 25 and 26, 2023 Facility number: 000562 Provider number: 155718 AIM number: 100267150 Census Bed Type: SNF/NF: 69 SNF: 3 Total: 72 Census Payor Type: Medicare: 17 Medicaid: 39 Other: 16 Total: 72 Northview Health and Living was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey.	{F 000}		

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 000}	Continued From page 1 Quality review completed June 1, 2023.	{F 000}		