

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155781</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/16/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNINGCREST NURSING AND MEMORY CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>915 S 27 ST SOUTH BEND, IN 46615</b>		
(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	
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Quality assurance Walk-thru Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/16/12</p> <p>Facility Number: 012199 Provider Number: 155781 AIM Number: 200989880</p> <p>Surveyor: Robert Booher, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Morningcrest Nursing and Memory Care center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The building was constructed in 1983 and remodeled in 2010. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and hard wired smoke detectors in the resident rooms. The facility has a capacity of 32 and had a census of 23 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

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K 000	Continued From page 1 All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.  Quality Review by Dennis Austill, Life safety Code Supervisor on 07/17/12.	K 000			