

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2024	
NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 475 NORTH NILES AVENUE, SOUTH BEND, , 46617					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00438592 and IN00438657. Complaint IN00438592 - No deficiencies related to the allegations are cited. Complaint IN00438657 - No deficiencies related to the allegations are cited. Survey date: July 26 & 29, 2024 Facility number: 013149 Residential Census: 56 Morning View Nursing and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00438592 and IN00438657. Quality Review completed on 8/5/2024.	R 0000					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See

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