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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CENTER	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 Intakes 466306 and 468072. Intake 466306 - No deficiencies related to the allegations are cited. Intake 468072 - State deficiencies related to the allegations were cited at R0036 and R0214. Survey date: March 3rd and 4th, 2026. Facility number: 13149 Residential Census: 49 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 3/6/2026	R 0000		

R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the physician was notified timely after a resident's fall for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: The clinical record of Resident D was reviewed on 3/3/2026 at 1:40 P.M. The resident's diagnoses included, but were not limited to: hypertension, hyperlipidemia and Alzheimer's disease. A Service Plan, dated 12/16/2025, indicated Resident D had fall prevention interventions including, but not limited to: clutter free	R 0036	**R036 – Physician Notification** **Corrective action for the resident affected** Resident D’s medical record was reviewed. The physician and hospice provider were notified of the resident’s fall and subsequent complaints of pain, and the resident was later transferred to the emergency department for further evaluation. Documentation regarding physician notification has been clarified in the resident record. No further negative outcomes were identified. **How the facility will identify other residents who may be affected** All resident fall incidents from the previous **30 days** were reviewed by the Director of Nursing (DON) to ensure physician notification occurred according to facility policy. Any missing documentation was corrected as appropriate. **Measures put in place to prevent recurrence** The facility has implemented the following corrective measures: • Re-education of all licensed nurses and nursing assistants on the **Fall Management**	03/16/2026

	environment, assistive devices available and in good repair, bed in low position at night, personal items and call light are within reach, and non-glare, soft lighting at night. A Nursing Note, dated 12/25/2025 at 5:36 A.M., indicated the resident had been lowered to the floor by staff but had not indicated whom had assisted the resident down to the floor. A Nursing Note, dated 12/26/2025 at 9:39 A.M., indicated the hospice nurse was notified of the resident's fall on 12/25/2025. A Nursing Note, dated 12/27/2025 at 3:16 P.M., indicated the resident was transferred to a local emergency room due to the resident's continued complaints of pain. During an interview, on 3/4/2026 at 10:15 A.M., the Director of Nursing (DON) indicated the hospice facility had been notified of the resident's fall on 12/26/2025. The DON indicated she had documented the physician notification on 12/30/25. On 3/4/2026 at 10:40 A.M., the Director of Nursing (DON) provided a policy titled, "Fall Management Program," reviewed 5 2023 and indicated		**Program policy**, including: • Immediate reporting of all falls to the nurse • Timely physician notification requirements • Documentation requirements • Reinforcement that **any fall must be reported immediately to the charge nurse**, regardless of whether injury is suspected. • Licensed nurses were educated on the requirement to notify the physician: • immediately when injury is suspected, or • during normal business hours if no injury is present, per policy. **Monitoring to ensure ongoing compliance** The Director of Nursing or designee will: • Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • Any identified concerns will result in immediate	

	the policy was the one currently used by the facility. The policy indicated " ...A "fall" refers to unintentionally coming to rest on the ground, floor or other lower level ...The physician will be contacted immediately, if there are injuries, and orders will be obtained ...if there are no injuries, notify the physician during normal business hours ..." This citation relates to Intake 468072		re-education and corrective action • The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance to verify physician notification and documentation occurred according to policy. Results of audits will be reviewed in the **Quality Assurance Performance Improvement (QAPI)** program, and additional interventions will be implemented if concerns are identified.	
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a licensed nurse assessed a resident after a	R 0214	**R214 – Licensed Nurse Assessment After Change in Condition** **Corrective action for the resident affected** Resident D’s fall incident was reviewed with nursing staff. The resident did receive follow-up care; however, the expectation for **immediate nurse assessment after any fall** was reinforced with staff. The staff member involved in the failure to timely report the fall is no longer employed by the facility.	03/09/2026

change in condition for 1 of 3 residents reviewed for falls. (Resident D)

Finding includes:

The clinical record of Resident D was reviewed on 3/3/2026 at 1:40 P.M. The resident's diagnoses included, but were not limited to: hypertension, hyperlipidemia and Alzheimer's disease.

A Service Plan, dated 12/16/2025, indicated Resident D had fall prevention interventions included but not limited to: clutter free environment, assistive devices available and in good repair, bed in low position at night, personal items and call light are within reach, and non-glare, soft lighting at night.

During an interview, on 3/4/2026 at 9:25 A.M., Resident D's representative indicated he had been living with the resident at the time of her fall on 12/25/2025. The resident representative indicated Resident D was being toileted by a facility aide when he heard a loud noise from the bathroom and the resident had called out in pain. The representative indicated he had walked into the bathroom and saw Resident D lying on the floor. The resident representative indicated he and the facility aide had assisted

How the facility will identify other residents who may be affected

The Director of Nursing completed a review of fall incidents from the prior **30 days** to ensure a licensed nurse assessment occurred after each fall or change in condition.

Measures put in place to prevent recurrence

The facility implemented the following interventions:

- Re-education of all nursing staff and CNAs on:
  - Immediate reporting of falls to a nurse
  - Requirement for **immediate licensed nurse assessment** after any fall
  - Proper incident reporting procedures
- Nursing staff were instructed that residents must **not be moved from the floor until assessed by a nurse**, unless there is immediate safety risk.
- The Fall Management Program policy was reviewed with staff and expectations reinforced.

	Resident D from the floor and had walked her back to her bed to lie down. The resident representative indicated the aide had not called for a nurse to assess the resident prior to moving the resident off of the floor. During an interview, on 3/4/2026 at 10:05 A.M., the Director of Nursing (DON) indicated Resident D had incurred a fall on 12/25/2025 but the Certified Nursing Assistant (CNA) had not reported the fall in a timely fashion to the nurse. The DON indicated the CNA had reported the fall to the nurse much later in the shift and the nurse had then assessed the resident. However, Resident D was already asleep in her bed and the nurse had not wanted to disturb or awaken the resident so she had not assessed the resident. The DON indicated the CNA had been terminated for failure to notify the nurse of the fall. An Incident Statement, dated 12/25/2025, from CNA 2, indicated the CNA had assisted the resident to the floor but had failed to notify the nurse of the assisted fall to the floor until "a couple of hours later." An Incident Statement, dated 12/25/2025, from LPN 3, indicated when she had been informed of Resident D's fall,		**Monitoring to ensure ongoing compliance** The Director of Nursing or designee will: • Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • Any identified concerns will result in immediate re-education and corrective action • The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance to ensure a licensed nurse assessment occurred immediately following any fall or change in condition. Audit findings will be reviewed in the **QAPI program** to ensure sustained compliance.	

	which had occurred previously in the shift, she had gone to the resident's room but the resident was sleeping. The nurse indicated she had assessed the resident when the call light had been activated, later in the shift. On 3/4/2026 at 10:40 A.M., the Director of Nursing (DON) provided a policy titled, "Fall Management Program," reviewed 5 2023 and indicated the policy was the one currently used by the facility. The policy indicated, " ...A "fall" refers to unintentionally coming to rest on the ground, floor or other lower level ...Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided ..." This citation relates to Intake 468072			

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 instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMitchell F. Craven	TITLEAdministrator	(X6) DATE03/16/2026