

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013149	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/29/2024
NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CEI			STREET ADDRESS, CITY, STATE, ZIP CODE 475 NORTH NILES AVENUE SOUTH BEND, IN 46617		
(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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00438592 and IN00438657.</p> <p>Complaint IN00438592 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00438657 - No deficiencies related to the allegations are cited.</p> <p>Survey date: July 26 & 29, 2024</p> <p>Facility number: 013149</p> <p>Residential Census: 56</p> <p>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.</p> <p>Quality Review completed on 8/5/2024.</p>	R 000			

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE