STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013149	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CEI	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	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00454089 and IN00452735. Complaint IN00454089 - No deficiencies related to the allegations are cited. Complaint IN00452735 - No deficiencies related to the allegations are cited. Survey dates: June 3 & 4, 2025 Facility number: 013149 Residential Census: 46 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 IN00454089 and IN00452735. Quality Review completed on 6/6/2025	R 000		