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

PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R-C	
		155752	155752 B. WING				
NAME OF PROVIDER OR SUPPLIER					ET ADDDESS OFT OTATE 7/D OODE	05/10/2017	
NAME OF PI				ET ADDRESS, CITY, STATE, ZIP CODE			
MORNINGSIDE NURSING AND MEMORY CARE CENTER				18325 BAILEY AVE			
				SOU	TH BEND, IN 46637		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	TS	{F 0	00}			
		e to the Recertification and irvey completed on March 27,					
	Review Date: May						
	Facility Number: 00						
	Provider Number:						
	AIM Number: 2008						
	was found to be in 483, Subpart B and	ng and Memory Care Center compliance with 42 CFR Part d 410 IAC 16.2, in regard to the Review to the Recertification e Survey.					

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE