STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15E683	A. BUILDING B. WING	00	05/12/2017
		.02000	STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/ 12/20 11
NAME OF I	PROVIDER OR SUPPLIEF	₹		WASHINGTON ST	
MORGA	NTOWN HEALTH C	CARE		ANTOWN, IN 46160	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
F 0000	REGULATORT OR	LESC IDENTIFTING INFORMATION)	IAG	,	DATE
Bldg. 00	This wisit was fo	n a Danasti Cantina and	F 0000		
	State Licensure	or a Recertification and	F 0000		
	State Licensure	Survey.			
	Survey dates: M	May 4, 5, 9, 10, 11, and			
	12, 2017	ing 1, 0, 2, 10, 11, with			
	Facility number:	: 000399			
	Provide number	: 15E683			
	AIM number: 1	00289100			
	Census bed type NF: 34				
	NF: 34 Total: 34				
	1011. 34				
	Census payor ty	ne:			
	Medicaid: 34	r · ·			
	Total: 34				
	These deficienci	es reflect State Findings			
	cited in accordar	nce with 410 IAC			
	16.2-3.1.				
	Quality Review cor	mpleted on May 19, 2017.			
	Quality Review con	npicted on May 17, 2017.			
F 0241	483.10(a)(1)				
SS=D Bldg. 00	DIGNITY AND RE	SPECI UF			
ычу. 00		ust treat and care for each			
	resident in a mani	ner and in an environment			
	that promotes ma	intenance or enhancement			
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

000399

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. W.	JILDING	00	COMPL	
		15E683	D. W	_		05/12/	2017
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					WASHINGTON ST		
MORGA	NTOWN HEALTH C	CARE		MORG	ANTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		ty of life recognizing each		TAG	DEFICIENCY)		DATE
		iality. The facility must					
		ote the rights of the					
	resident.	3					
	Based on observ	ration, interview, and	F 02	241	F-241		06/11/2017
	record review, tl	ne facility failed to ensure			1. VELCRO STOP SIGNS	,	
	a resident's priva	acy in that wandering			WERE PLACED AT	,	
	residents (Resid	ent 36 and Resident 37)			DOORWAYS TO PREVENT		
	were observed s	itting on the bed in			CONFUSED RESIDENTS FR	ROM	
	another resident	's room (Resident 30).			ENTERING ROOMS OF		
					RESIDENTS.  2. ALL RESIDENTS HAVE	=	
	Findings include:				THE POTENTIAL TO BE	_	
					AFFECTED.		
	On 5/11/2017 at	12:59 p.m., Resident 36			3. ALL RESIDENTS WER	E	
		were observed sitting on			ASKED IF THEY WANTED A STOP SIGN ACROSS DOOR	99	
	the roommate's l	bed in Resident 30's			OF THEIR ROOMS TO	.o	
	room. Resident	30 was observed to be			PREVENT OTHERS FROM		
	visually upset ar	nd raising her left hand in			ENTERING. STOP SIGNS		
		30 indicated by nodding			WERE PLACED AT DOORS		
		as upset by Resident 36			RESIDENTS WHO WANTED STOP SIGNS. STAFF TO		
	1 -	being in her room.			MONITOR WANDERING		
		8			CONFUSED RESIDENTS AS	;	
	On 5/12/2017 at	10:55 a.m., the Director			MUCH AS POSSIBLE TO		
		N) indicated Resident 36			PREVENT FROM ENTERING OTHERS ROOMS. SSD WIL		
		should not be in			ASK RESIDENTS MONTHLY		
		om. The facility will try			THEY WISH TO HAVE A STO		
		top sign across Resident			SIGN AT THEIR DOOR AND		
	30's door.	top sign across resident			UPON ADMISSION OF NEW		
	30 S GOO1.				RESIDENTS IF THEY WISH		
	On 5/12/2017	2.10 n m. a ravious of			HAVE STOP SIGN AT THEIR DOOR. SSD TO CHECK ON	`	
		2:10 p.m., a review of			RESIDENT #30 DAILY FOR 6	60	
	the Minimum Data Set (MDS) assessment completed on 4/16/2017,				DAYS.		
					4. HFA, DON OR DESIGN		
		ent 30 had a Brief			WILL MONITOR DAILY. THE QA COMMITTEE WILL REVI		
		ental Status (BIMS) score			FOR 6 MONTHS. THE FACIL		
	of 09, indicating	the resident was			TORO MONTIO. THE PACIE	.1 1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SI COMPLE		
		15E683	B. WING	<u></u>	05/12/2	
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST BANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	interviewable an impaired.  On 5/12/2017 at the MDS assessr 3/13/2017, indic score could not be resident being ra and a behavior of daily.  On 5/12/017 at 2 MDS assessmen indicated Resident not be calculated rarely/never und wandering was room 5/11/2017 at Administrator progressive resident Rights 3/29/2017, and in currently being to policy indicated,	2:15 p.m., a review of ment completed on ated Resident 36's BIMS be calculated due to rely/never understood f wandering occurred  2:16 p.m., a review of the trompleted on 4/6/2017, and 37's BIMS score could due to resident being erstood and a behavior of not exhibited.  2:30 p.m., the rovided the policy set with a revised dated of andicated it was the policy ased by the facility. The " (h) The resident has onal privacy (1) includes	TAG	WILL FOLLOW THE RECOMMENDATIONS OF COMMITTEE.  5. DATE OF COMPLE 6/11/17.	= QA	DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG <u>00</u>	COMPLETED	
		15E683	B. WING		05/12/2017	
			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		140	W WASHINGTON ST		
MORGAN	NTOWN HEALTH C	ARE	МС	DRGANTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD )		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF	CROSS-REFERENCED TO THE APPROF	RIATE COMPLETION  DATE	
F 0248 SS=D Bldg. 00	(c) Activities.  (1) The facility mu comprehensive as and the preference ongoing program their choice of actifacility-sponsored activities and indeed designed to meet support the physic psychosocial well-encouraging both interaction in the consumption of the confined activities and interaction in the confined activities and interaction in the confined activities and interesting and interesting included on 5/9/17 at 9:3 observed to be a geriatric chair (a chair designed to out of the confined able to sit comformations while the	group and individual pendent activities, the interests of and cal, mental, and being of each resident, independence and community.  ation, interview, and he facility failed to so to meet a resident's set for 1 of 3 residents ivities. (Resident 33)	F 0248	F-248  1. RESIDENT 33 WAS BY SSD THAT A RADIO WE RESONAL USE, ALSO, HE PERSONAL USE, ALSO, HE PERSONAL USE, ALSO TO AND TURNED IT ON FOUT OF HER PERSONAL FUNDS. SSD CHECKED TO AND TURNED IT ON FOUT OF THE RESIDENT.  2. ALL RESIDENTS HAD THE POTENTIAL TO BE AFFECTED.  3. EACH RESIDENT WE BE CHECKED FOR PROPIOUSUAL OR HEARING STIMULATION DEVICES FOR PROPIOUSUAL OR	OULD R IER FO ASE THE DR VE ILL ER	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPL	ETED
		15E683	B. W	ING		05/12/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER			1	WASHINGTON ST		
MORGAI	NTOWN HEALTH C	ARE			ANTOWN, IN 46160		
					1141 O VVIV, 114 70 100		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	quality of life) in	the middle of her room			THEIR PERSONAL USE AND	)	
	with no television or radio on.				ENJOYMENT. STAFF OR	_	
					DESIGNEE WILL CHECK THI	E	
	On 5/10/17 at 10	29 a.m., Resident 33			PERSONAL NEEDS OF RESIDENTS FOR PROPER		
		be awake in bed laying			VISUAL OR HEARING		
					STIMULATION DEVICES,		
	_	with no television or			DAILY.		
	radio on.				4. HFA, DON, OR		
					DESIGNEE,SSD, WILL		
	On 5/11/17 at 12	2:58 p.m., Resident 33			MONITOR DAILY. THE QA		
	was observed to	be awake in bed and			COMMITTEE WILL REVIEW		
	watching the roo	ommate's television.			FOR 6 MONTHS. THE	_	
	3				FACILITY WILL FOLLOW THI RECOMMENDATIONS FO TH		
	On 5/12/17 at 0.	29 a.m., Resident 33			QA COMMITTEE.	IL	
					5. DATE COMPLETED		
		be awake and sitting in a			6/11/17.		
	geriatric chair w	ith no television or music					
	on.						
	On 5/10/17 at 10	2:41 a.m., Resident 33's					
		as reviewed. Diagnoses					
		limited to: age related					
	•	· ·					
	macular cataract	s, psychosis, and					
	delusions.						
	A review of Resi	ident 33's activities					
	careplan dated 5/	/20/16, indicated, "I					
	attend some sche	eduled group activities					
		me, Bingo, Special					
		itsI enjoy listening to					
	_	ssist me with getting					
		• •					
		ite me to anyenjoys					
	classic rock"						
	A review of Resi	ident 33's significant					
		m Data Set (MDS)					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15E683	B. W.	ING		05/12/	2017
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
MORGAN	NTOWN HEALTH (	CARE			WASHINGTON ST ANTOWN, IN 46160		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		d 2/7/17, indicated she					
	preferred to liste	en to music.					
		sident 33's activity					
	calendar record, for May 2017, indicated						
	she attended 1 to 1 activities on May 1, 2,						
	3, 4, 5, 8, 9, 10, and 11, but did not attend						
	the music activity	ty on May 2 or 9.					
	A review of Resident 33's activity small group/1:1 participation indicated the following:						
	On $5/1/17$ , the	1 to 1 activity was					
	indicted as activ	re participation with being					
	read to and play	ing color cards.					
	On $5/3/17$ , the	1 to 1 activity was					
	indicated as acti	ve participation with					
	using sphere bal	ll and paying color cards,					
	On 5/8/17, the s	small group activity was					
	indicated as acti	ve with being read to and					
	using sensory pi	illow.					
	On 5/10/17, the	1 to 1 activity was					
	indicated as acti	ve with being read to					
	resident and using	ng sphere ball.					
	During an interv	view on 5/10/17 at 11:38					
	a.m., Certified	Nurse Aide (CNA) 2					
	indicated Reside	ent 33 does not attend					
	many activities	because she likes to stay					
	in bed. Residen	t 33 does not have a radio					
	but will watch th	he roommate's television.					
	During an interv	view on 5/11/17 at 1:38					
	p.m., Activity A	ssistant indicated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E683		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/12/2017		
	PROVIDER OR SUPPLIER  NTOWN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Resident 33 was on 1 to 1 activities program and liked to be read to, touch sensory pillow, and liked to listen to music. She was unsure if Resident 33 had a radio in her room.  During an interview on 5/11/17 at 3:16 p.m., Resident 33 indicated she liked to listen to music and would like a radio.  During an interview on 5/12/17 at 11:15 a.m., Social Services Designee (SSD) indicated Resident 33 liked to listen to music and would attend music group activities for short periods of time. The facility provides a radio to residents and will get Resident 33 a radio.  On 5/12/17 at 3:11 p.m., SSD provided the Activities Policy, dated unknown, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of [] Facility to provide an activities program that is appropriate to the needs and interests of each resident that will encourage self-care, resumption of normal activities, maintenance of optimal self functioning and contact with the environment"					

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	OF DEFICIENCIES CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E683	(X2) MULTIPLE ( A. BUILDING B. WING	OO OO	COM	E SURVEY PLETED 2/2017
	OVIDER OR SUPPLIER		140 W	T ADDRESS, CITY, STATE, ZIP COE V WASHINGTON ST GANTOWN, IN 46160	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
SS=D   I   I   I   I   I   I   I   I   I	PLANS 483.20 (d) Use. A facility assessments complete in the results develop, review are comprehensive can assess to the results develop, review are comprehensive can assess to the facility must be comprehensive process that the comprehensive is a comprehensive as a comprehensive and times as a comprehensive as	must maintain all resident pleted within the previous esident's active record is of the assessments to not revise the resident's re plan.  The Care Plans  Set develop and implement person-centered care plan consistent with the forth at §483.10(c)(2) and at includes measurable eframes to meet a gramma, and mental and les that are identified in the sessment. The re plan must describe the resident's highest al, mental, and being as required under or §483.40; and at would otherwise be 33.24, §483.25 or §483.40 and due to the resident's under §483.10, including				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E683	B. W.		00	05/12/	
		132003	D. ,,,			03/12/	2017
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE  WASHINGTON ST		
MORGA	NTOWN HEALTH C	CARE			ANTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	rehabilitative servi provide as a resul recommendations the findings of the its rationale in the (iv)In consultation resident's represe (A) The resident's desired outcomes (B) The resident's for future discharge document whether the return to the commany referrals to locand/or other appropurpose.  (C) Discharge plan care plan, as approvith the requirement (c) of this section. Based on observing record review, the a care plan was a contracture (defifixed high resistation and failed to for staff implements of the section of the	If a facility disagrees with PASARR, it must indicate resident's medical record.  with the resident and the intative (s)- goals for admission and  preference and potential ge. Facilities must resident's desire to munity was assessed and cal contact agencies opriate entities, for this in the comprehensive repriate, in accordance ents set forth in paragraph ation, interview, and the facility failed to ensure	F 02	279	F-279  1. CONTRACTURE CAREPLAN WAS COMPLETE FOR RESIDENT 20 ON 5/15/: STAFF WERE IMMEDIATELY IN-SERVICED ON POSITIONING RESIDENTS IT CHAIRS USING PILLOWS TO MAINTAIN PRPER BODY ALIGNMENT. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ANY RESIDENT WITH.	17. N )	06/11/2017
	reclining chair d someone to get of	esigned to allow out of the confines of			CONTRACTURE NOTED WIL BE CAREPLANNED EVEN IF		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15E683	B. W	ING		05/12/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			WASHINGTON ST		
MORGAN	NTOWN HEALTH C	ADE			ANTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		able to sit comfortably in			THEY REFUSE RANGE OF		
	a variety of posi	tions while being fully			MOTION, CORRECTIVE DEVICES OR PT SERVICES.		
	supported in ord	er to maintain and			CAREPLAN FOR RESIDENT		
	improve their qu	ality of life) (Resident			WAS UPDATED TO INCLUDE		
	16).				POSITIONING WITH PILLOW	S	
	,				WHILE IN GERI CHAIR, PT		
	Findings include	·			WILL INSERVICE STAFF ON		
	i mamgs merade	·•			5/30/17 ON POSITIONING		
	1) On 5/5/17 of	10:20 a m Ragidant 20			RESIDENTS IN CHAIRS TO PROMOTE PROPER BODY		
	1.) On 5/5/17 at 10:30 a.m., Resident 20				ALIGNMENT.		
	was observed to have contracture of their				4. HFA, DON, OR		
	left arm and fingers.				DESIGNEE,SSD CONSULTAI	NT,	
					SSD, WILL MONITOR		
	On 5/10/17 at 9:	27 a.m., Resident 20 was			MONTHLY FOR COMPLETIO	N	
	observed to have	e contracture of their left			OF CAREPLANS. HFA, DON,		
	arm and fingers.				STAFF OR DESIGNEE WILL MONITOR DAILY FOR		
					POSITIONING OF RESIDENT	S	
	On 5/5/17 at 11:	10 a.m., the Director of			QA TO MONITOR FOR 6	0.	
		indicated Resident 20			MONTHS. THE FACILITY WIL	.L	
	• • •	e of their left arm and			FOLLOW THE		
		no ROM to the left arm			RECOMMENDATIONS OF QA	4	
	and fingers.	no ROW to the left aim			COMMITTEE.  5. DATE OF COMPLETION	N	
	and inigers.				6/11/17.		
	05/11/17 / 0	40 Parida 4 20					
		40 a.m., Resident 20					
		t hand does not hurt and					
		unable to straighten his					
	left fingers.						
	On 5/11/17 at 1:	53 p.m., Certified Nurse					
	Aide (CNA) 2 in	ndicated Resident 20					
	` ′	ipate in group or					
	•	to the left arm or					
	fingers.						
	11115010.						
	On 5/11/17 at 2:	29 p.m., The Director of					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E683	(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/12/2017	
	PROVIDER OR SUPPLIER		140 W	T ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST GANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETIO DATE	N
	was admitted wi	indicated Resident 20 th left arm and hand ne refused any ROM to and.				
	clinical record w included but wer	rkinson's Dementia,				
	Assessment indic On 6/3016, left v moderate ROM. On 9/27/16, left moderate ROM. On 12/21/16, left had moderate ROM.	ident 20's Contracture cated the following: wrist and left fingers had wrist and left fingers had t wrist and left fingers DM. wrist and left fingers had				
	lacked a care pla	ident 20's care plans in to address care or left wrist or hand				
	Resident 20 did	2:56 a.m., DON indicated not have a care plan to treatment of assessed				
	On 5/12/17 at 12 Administrator pr	2:15 p.m., The rovided the Plan of Care				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E683	(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE COMPL <b>05/12</b> /	ETED
	PROVIDER OR SUPPLIER NTOWN HEALTH C		140	) W V	DDRESS, CITY, STATE, ZIP CODE VASHINGTON ST NTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated the polloeing used by the indicated, "Ear Plan of Care so to the care necessar achieve and/or in practical physical psychological with 5/10/17 at 11:00 clinical record with included, but not disease.  The Minimum Et (MDS) quarterly indicated the resident on state bed or alternate at the dependent on state bed or alternate at the segmentation of the problem/concerning the position.  The resident's calcand revised 4/13 problem/concerning to balance himself upright position.	ellbeing"2.) On A.M., Resident 16's ras reviewed. Diagnosis t limited to Parkinson's  Pata Set Assessment review, dated 1/24/17, ident was totally off for his positioning in furniture.  der, dated 3/10/16, ident may be in a ne to his inability to or hold his torso in an					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15E683	B. W	ING		05/12/	2017
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
					WASHINGTON ST		
MORGAN	NTOWN HEALTH C	CARE		MORGA	ANTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
		be up and properly					
	positioned in the geriatric chair. The care plan lacked interventions for staff to						
	implement to achieve the goal of						
	maintaining proper positioning.  Resident 16 was observed sitting in a						
	geriatric chair and slouching to his left						
	with no interventions to support him in						
	an upright position on the following						
	dates, times, and locations:  5/4/17 at 12:30 P.M., in the dining room.						
	5/4/17 at 2:30 P.	•					
		A.M., in his room.					
	5/9/17 at 1:00 P.						
		A.M., in his room.					
		A.M., in the hallway by					
	the nurse's statio						
		P.M., in his room.					
		A.M., in the dining room.					
		A.M., in his room.					
		,					
	On 5/11/17 at 9:	50 A.M., CNA 2					
		ident had begun severely					
		left about two months					
		enefit from being					
	_	upright position. At this					
		isted the resident in					
		the geriatric chair and					
		n his left side and behind					
		sident indicated this					
		ch more comfortable to					
	him than slouchi						
	mini man sioucin	ing to ins left.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E683		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPL <b>05/12</b> /	ETED	
	ROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	was observed in slouching to the his geriatric chair on 5/12/17 at 10 of Nursing indicated progressive condisease had caus left in his geriatric would benefit from the keep him in an on 5/12/17 at 3: observed sitting an upright position his left side at head. The reside positioning felt in than slouching to on 5/12/17 at 12 Administrator progressive conditions and the politicated of the politicated of the politicated, "Earlan of Care so to the care necessaria."	left with no support in r.  2:05 A.M., the Director ated the resident's lition of Parkinson's ed him to slouch to his ic chair and the resident om the support of pillows in upright position.  15 P.M., the resident was in his geriatric chair, in on, supported by a pillow and a pillow behind his int indicated this much more comfortable or his left.  2:15 p.m., The ovided the Plan of Care icy, dated unknown, and icy was the one currently the facility. The policy ch resident shall have a hat he/she will receive by to enable him/her to maintain the highest all, mental, and				
ı						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	,		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		15E683	B. WI			05/12/	2017
	ROVIDER OR SUPPLIER			140 W V	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0282 SS=D Bldg. 00	CARE PLAN (b)(3) Comprehen The services provided into the services provided by accordance with expected of care.  Based on observing record review, the staff followed a cativities for 1 or activities (Reside failed to ensure sto provide the nearesident during management of the staff followed and activities (Reside failed to ensure sto provide the nearesident during management of the staff followed and activities (Reside failed to ensure sto provide the nearesidents reviews 36).  Findings include  1.) On 5/9/17 at was observed to geriatric chair (and chair designed to out of the confine staff of the staff of t	ided or arranged by the d by the comprehensive d undiffed persons in each resident's written plan ation, interview, and he facility failed to ensure care plan to provide f 3 residents reviewed for ent 33) and the facility staff followed a care plan ecessary assistance to a meal time for 1 of 3 ed for nutrition (Resident	F 02	82	F-282  1. FACILITY STAFF IN-SERVICED REGARDING NECESSITY OF FOLLOWING EACH RESIDENT'S PLAN OF CARE. STAFF WILL BE INFORMED WHEN SIGNIFICANT CHANGES AR UPDATED TO CARE PLAN. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. RESIDENT #36 CARE PLAN WAS REVIEWED AND UPDATED. RESIDENT 36 WI BE WEIGHED WEEKLY TO MONITOR WGT. HE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS, BETWEEN MEALS A AT HS, BENECALORIE LIQU ADDED TO FOOD WITH MEALS, REMERON 15MG PO	E E LL ND ID	06/11/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15E683	B. WI	NG		05/12/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			WASHINGTON ST		
MODOAI		NADE			ANTOWN, IN 46160		
MURGAI	NTOWN HEALTH C	ARE		WORGA	ANTOWN, IN 46160		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	positions while b	peing fully supported in			QHS TO STIMULATE HIS		
	order to maintain and to improve their				APPETITE, ENSURE 237ML		
	quality of life) in the middle of her room				(1CAN) AT 10A, 3P AND 9P,		
					AND FREQUENT SNACKS		
	with no television	on or radio on.			INCLUDING CAKES, COOKIE	S	
					AND ICE CREAM. OT TO		
	On 5/10/17 at 10	):29 a.m., Resident 33			ASSESS RESIDENT #33 ON		
		be awake in bed laying			6/1/2017 FOR INDEPENDENC		
		, ,			OF EATING.RESIDENT WILL		
	_	with no television or			SEATED AT FEEDING TABLE		
	radio on. On 5/11/17 at 12:58 p.m., Resident 33				SDR FOR ALL MEALS SO HE		
					CAN BE CUED AND ASSISTE		
					TO EAT. RESIDENT #33 CAP	KE	
	was observed to be awake in bed and				PLAN WAS REVIEWED AND UPDATED. EACH RESIDENT		
					WILL BE CHECKED FOR		
	watching the roc	ommate's television.			PROPER VISUAL OR HEARII	NG	
					STIMULATION DEVICES FOR		
	On 5/12/17 at 9:	29 a.m., Resident 33			THEIR PERSONAL USE AND		
	was observed to	be awake and sitting in a			ENJOYMENT. ACTIVITY		
		ith no television or music			ASSISTANT AND NURSING		
		itii ilo television oi masie			WILL CHECK THE PERSONA	ιL	
	on.				NEEDS OF RESIDENTS FOR		
					PROPER VISUAL OR HEARII	NG	
	On 5/10/17 at 10	0:41 a.m., Resident 33's			STIMULATION DEVICES,		
	clinical record w	vas reviewed. Diagnoses			DAILY. A RADIO WAS		
		t limited to: age related			PURCHASED FOR RESIDEN	T	
	· ·	s, psychosis, and			#33 PERSONAL USE AND		
		s, psychosis, and			RESIDENT IF SHE WISHES 1	ГО	
	delusions.				ATTEND ACTIVITIES DAILY		
					AND TV WILL BE ON IF		
	A review of Res	ident 33's activities			RESIDENT REQUEST IT.		
	careplan dated 5	/20/16, indicated, "I			4. HFA, DON OR		
		eduled group activities			DESIGNEE,STAFF WILL		
					MONITOR DAILY. THE QA		
		me, Bingo, Special			COMMITTEE WILL REVIEW	TV	
	parties, and ever	ntsI enjoy listening to			FOR 6 MONTHS. THE FACILI WILL FOLLOW THE	I Y	
	music. Please as	ssist me with getting			RECOMMENDATION OF THE	=	
		ite me to anyenjoys			QA COMMITTEE.	_	
	classic rock"	- · · · · · · · · · · · · · · · · · · ·			5. DATE COMPLETED		
	Classic lock				6/11/17.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	15E683	B. W.		00	05/12/2017	
		10000		_	ADDRESS, CITY, STATE, ZIP CODE	00/12/2017	
NAME OF F	PROVIDER OR SUPPLIER			1	WASHINGTON ST		
MORGAN	NTOWN HEALTH C	ARE			ANTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLE DATE	
1110		ident 33's significant		1110		3.112	
	change Minimum Data Set (MDS)						
	assessment, dated 2/7/17, indicated she preferred to listen to music.  A review of Resident 33's activity calendar record for May 2017, indicated						
		o 1 activities on May 1, 2,					
		and 11, but did not					
		activity on May 2 or 9.					
	attend the music activity on May 2 of 7.						
	A review of Res	ident 33's activity small					
	group/1:1 partici	pation indicated the					
	following:						
	· ·	to 1 activity was					
		e participation with being					
	read to and playi	· ·					
	· ·	to 1 activity was					
		ve participation with					
	• •	l and paying color cards. mall group activity was					
	· · · · · · · · · · · · · · · · · · ·	we with being read to and					
	using sensory pil						
		1 to 1 activity was					
	· · · · · · · · · · · · · · · · · · ·	ve with being read to					
	resident and usin	•					
		ident 33's activity					
		no music activity					
	provided as indic	cated on her care plan.					
	During an interv	iew on 5/10/17 at 11:38					
	_	Nurse Aide (CNA) 2					
	indicated Reside	nt 33 does not attend					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15E683	B. W	TING		05/12/	/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
MORGAN	NTOWN HEALTH C	ARE			WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		because she likes to stay					
	in bed. Resident 33 does not have a radio						
	but will watch resident's roommate television.						
	television.						
	During an interview on 5/11/17 at 1:38						
		ssistant indicated					
		on 1 to 1 activities					
		ed to be read to, touch					
	sensory pillow, and liked to listen to music. She was unsure if Resident 33						
had a radio in her room.							
	nad a radio in noi room.						
	During an interv	iew on 5/11/17 at 3:16					
		3 indicated she liked to					
	listen to music a	nd would like a radio.					
	During an interv	iew on 5/12/17 at 11:15					
	a.m., Social Serv	vices Designee (SSD)					
		nt 33 liked to listen to					
		l attend music group					
		rt periods of time. The a radio to residents and					
	J 1	t 33 a radio. 2.) During					
	_	5/8/17 at 11:30 a.m.,					
		fe indicated when she					
	comes to visit hi	m, he needs an hour to					
		nstant reminders to bring					
		outh. She further					
		nable to cut up his food built-up silverware					
	would be a good	_					
		1					
	On 5/8/17 at 12:	15 p.m., Resident 36's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E683		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPI 05/12	LETED	
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	main dining room observed to be unwas observed to Resident 36's me	ncut and Resident 22 reach over and cut up				
	observed at the r staff while eating Staff was observ	54 a.m., Resident 36 was nurses's station talking to g a package of cookies. ed to ask him multiple ating his cookies.				
	was observed ear room without ass taco salad while fell on his clothin resident indicate could not get the resident was then sherbet with his instructed Reside	ting in the main dining sistance. He was eating multiple food particles and the floor. The dhe was very hungry but food to his mouth. The hobserved to grab his bare hands. Resident 22 ent 36 to use his spoon d to hand him a spoon				
	was observed ear dining room with 5 was observed t and eat. The resi his meal tray as remove his tray,	2:35 p.m., Resident 36 ting lunch in the main nout assistance. Resident to tell him to sit down dent consumed 75% of LPN 1 was observed to scrape his leftovers into acle, and leave the room.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E683		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE COMPI <b>05/12</b>	LETED	
	PROVIDER OR SUPPLIER		140 W \	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Resident 36 was the dining room	observed to sit alone in at the table.				
	clinical record wa	2:04 a.m., Resident 36's as reviewed. Diagnoses s not limited to: y, Alzheimer's disease,				
	A Nutritional Assessment, dated 3/9/17 indicated, " Eating patterns: independent. set up. supervisionres [resident] feeds himself a reg [regular] nas [no added salt] diet after set up eats 75-100% of lunch et [and] supper He has lost 26 lbs [pounds] since admission 1 year ago. wt [weight] usually steadily declines "					
	A review of Res included, but we	ident 36's care plans re not to:				
	participate in inc [activities of dail [due to] dementi disturbance, Alz hydrocephalus [a within the brain] [ventriculoperitor depression, postor of the spine], spi of the spin], seiz	y living] activity D/T a [with] behavioral heimer's, agitation, accumulation of fluid				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
	15E683	B. WING		05/12/2017
	PROVIDER OR SUPPLIER	140 W W	DDRESS, CITY, STATE, ZIP CODE VASHINGTON ST NTOWN, IN 46160	
(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 APPROPR DEFICIENCY)	
	and [with] cueing"  On 5/12/17 at 11:51 a.m., LPN 1 indicated Resident 36 usually eats in the main dining room and sometimes will eat in the assisted dining room if he needs a little more help.  On 5/12/17 at 3:05 p.m., interview with CNA 1 indicated if a resident needed to be watched closer or needed cueing, the resident would go into the assisted dining room where staff could keep a closer eye on them.  3.1-36(g)(2)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.  483.25 (k) Pain Management. The facility must ensure that pain			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLI	ETED
		15E683	B. WING	3		05/12/2	2017
				CTDEET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			VASHINGTON ST		
MODOAN							
MORGAI	NTOWN HEALTH (	DARE		WORGA	ANTOWN, IN 46160		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		rovided to residents who					
		ices, consistent with					
	_ ·	dards of practice, the					
		erson-centered care plan,					
	and the residents	goals and preferences.					
	(I) Dialysis. The facility must ensure that residents who require dialysis receive such						
		ent with professional					
		tice, the comprehensive					
	person-centered care plan, and the residents' goals and preferences.  Based on observation, interview, and						
			F 030	9	F-309		06/11/2017
		he facility failed to					
		•			1. STAFF WERE		
		ing support in order to			IMMEDIATELY INSERVICED ON		
	_	nt from leaning to the		POSITIONING RESIDENTS IN			
	side while seate	d in a geriatric chair (a			CHAIRS USING PILLOWS TO MAINTAIN PROPER BODY	'	
	medical reclinin	g chair designed to allow			ALIGNMENT.		
	someone to get	out of the confines of			2. ALL RESIDENTS HAVE	<u>-</u>	
	_	able to sit comfortably in			THE POTENTIAL TO BE	•	
		tions while being fully			AFFECTED.		
					3. CAREPLAN FOR		
	* *	ler to maintain and			<b>RESIDENT 16 WAS UPDATE</b>	D	
	improve their qu	uality of life). (Resident			TO INCLUDE POSITIONING		
	16).				WITH PILLOWS WHILE IN GE		
					CHAIR, PT WILL INSERVICE		
	Findings include	2:			STAFF ON 5/30/17 ON	.	
					POSITIONING RESIDENTS II CHAIRS TO PROMOTE	<b>'</b>	
	On 5/10/17 at 1	1:00 A M Resident 16's			PROPER BODY ALIGNMENT	-	
	On 5/10/17 at 11:00 A.M., Resident 16's				4. HFA, DON, OR	.	
		vas reviewed. Diagnosis			DESIGNEE, STAFF, PT WHEN	ν l	
	1	t limited to Parkinson's			IN BULDING WILL MONITOR		
	disease.				DAILY FOR POSITIONING O		
	The Minimum Data Set Assessment (MDS) quarterly review, dated 1/24/17,				RESIDENTS. QA TO MONITO	OR	
					FOR 6 MONTHS. THE FACIL	ITY	
					WILL FOLLOW THE		
	`				RECOMMENDATIONS OF TH	1E	
	indicated the res	sident was totally			QA COMMITTEE.		

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	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE DPRIATE	(X5) COMPLETION DATE
	dependent on state bed or alternate	off for his positioning in furniture.		5. DATE COMPLETED 6/11/17.		
	indicated the res geriatric chair du	der, dated 3/10/16, ident may be in a ue to his inability to or hold his torso in an				
	Resident 16 was observed sitting in a geriatric chair and slouching to his left with no interventions to support him in an upright position on the following dates, times, and locations:					
	5/4/17 at 2:30 P. 5/5/17 at 10:00 P. 5/9/17 at 1:00 P. 5/10/17 at 9:15 P. 5/10/17 at 11:30 the nurse's station 5/10/17 at 2:00 I. 5/11/17 at 8:00 P.	A.M., in his room. M., in his room. A.M., in his room. A.M., in the hallway by				
	slouching to the ago and would be supported in an attime, CNA 2 assessitting upright in	ident had begun severely left about two months enefit from being apright position. At this isted the resident in the geriatric chair and in his left side and behind				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E683		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE COMPL <b>05/12</b> /	ETED	
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
		ident indicated this h more comfortable to ng to his left.				
	was observed in	left with no support in				
	of Nursing indicates progressive conduction disease had cause left in his geriatry would benefit from	2:05 A.M., the Director ated the resident's lition of Parkinson's ed him to slouch to his ic chair and the resident om the support of pillows in upright position.				
	observed sitting an upright position on his left side at head. The reside	nuch more comfortable				
	Administrator pr current Resident' 3/29/17. The pol must, "treat ea that promotes ma	30 P.M., the Facility ovided the facility's is Rights policy, dated, icy indicates the facility ich resident in a manner mintenance or his or her quality of				

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AND PLAN OF CORRECTION ID.		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E683	(X2) MULTIPLE CONSTRUCTION       (X3) DATE S         A. BUILDING       00       COMPL         B. WING       05/12/			ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	r <b>E</b>	(X5) COMPLETION DATE
F 0312 SS=D Bldg. 00	RESIDENTS (a)(2) A resident wactivities of daily linecessary service nutrition, grooming hygiene. Based on observing record review, the staff provided neresident during management of the staff provided neresidents reviewed 36).  Findings included During an intervalum, Resident 36 she comes to visit to eat meals and bring the food to cut up his food On 5/8/17 at 12:	s to maintain good g, and personal and oral ation, interview, and he facility failed to ensure excessary assistance to a heal time for 1 of 3 hed for nutrition (Resident  is iew on 5/8/17 at 11:30 his wife indicated when hit him, he needs an hour constant reminders to his mouth. He is unable his health of the series of the	F 0.	312	F-312  1. STAFF WERE INSERVICED ON 5/15/17 UTILIZING DINING TABLE IN SMALL DINING ROOM. RESIDENT #36 REASSESSE TO ESTABLISH HIS LEVEL OF INDEPENDENCE FOR EATIN BY OT ON JUNE 1, 2017. STAIN-SERVICED ON FACILITY POLICY FOR FEEDING PROGRAM.  2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED.  3. RESIDENT 36 WILL CONTINUE TO BE WEIGHED WEEKLY TO MONITOR WGTHE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS, BETWEEN MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO SERVICE WEIGHED WEEKLY TO MONITOR WGTHE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS, BETWEEN MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL TO THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HS, BENECARORIE LIQUID ADDITIONAL THE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HE WILL CONTINUE TO RECEIVE HEALTH SHAKES WITH MEALS AND AT HE WILL CONTINUE TO RECEIVE THE WILL CONTINUE TO RECEIVE T	D DF IG AFF	06/11/2017

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E683		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  IG 00	(X3) DATE SURVEY COMPLETED 05/12/2017				
	OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPROF	N (X5) BE COMPLETION DATE			
	observed to be used observed to Resident 36's mare reminded Resident The staff in the with cutting up the eat.  On 5/10/17 at 9: observed at the staff while eating Staff was observed times if he was observed ear room without as taco salad while fell on his clothing resident indicate could not get the resident was the sherbet with his instructed Resident was observed for his sherbet. Toom did not cut on 5/11/17 at 12 was observed ear dining room with 5 was observed and eat. The resident to Resident was the sherbet with his instructed Resident was observed and eat. The resident was observed and eat.	ncut and Resident 22 reach over and cut up		TO FOOD WITH MEALS, REMERON 15MG PO QHS STIMULATE HIS APPETIT ENSURE 237ML (1CAN) A 3P, 9P, AND FREQUENT SNACKS INCLUDING CAK COOKIES AND ICE CREAL RESIDENT #36 WILL BE IN SMALL DINING ROOM FO MEALS TO BE CUED AND ASSISTED WITH MEALS.  4. HFA, DON,OR DESID STAFF WILL MONITOR DATHE QA COMMITTEE WILL REVIEW FOR 6 MONTHS. FACILITY WILL FOLLOW RECOMMENDATIONS OF QA COMMITTEE.  5. DATE COMPLETED 6/11/17.	GTO E, T 10A, MES, M. N R GNEE, AILY. L THE THE			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
		15E683	B. W	ING		05/12/	/2017
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE VASHINGTON ST		
MORGAI	NTOWN HEALTH C	ARE			NTOWN, IN 46160		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	remove his tray,	scrape his leftovers into					
	a garbage receptacle, and leave the room.						
		observed to sit alone in					
	_	at the table. The staff in					
	_	did not assist with					
	culling up food (	or cue the resident to eat.					
	On 5/10/17 at 10:04 a.m., Resident 36's						
	clinical record w	as reviewed. Diagnoses					
	included, but was not limited to:						
	insomnia, anxiety, Alzheimer's disease, and delusions.						
	A Nutritional As	sessment, dated 3/9/17					
	indicated, " Ea	ating patterns:					
	independent. set	up. supervisionres					
	[resident] feeds l	nimself a reg [regular]					
	=	lt] diet after set up					
		lunch et [and] supper					
	He has lost 26 lb						
	_	ago. wt [weight] usually					
	steadily declines	"					
	A review of Res	ident 36's care plans					
	included, but we	-					
	3/28/16 "Droble	ms/Needs Inability to					
	participate in ind	_					
		ly living] activity D/T					
	-	a [with] behavioral					
		heimer's, agitation,					
	· ·	accumulation of fluid					
	within the brain]	[with] VP					
	[ventriculoperito	neal] shunt, major					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION 00	COMPLETED		
		15E683	B. WING		05/12/201	
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE CO	(X5) MPLETION DATE
	of the spine], spi of the spin], seiz	ural kyphosis [curvature nal stenosis [narrowing ures, anxiety, delusions elf [after] setup of tray g"				
	main dining roor	:51 a.m., LPN 1 nt 36 usually eats in the n and sometimes will eat ning room if he needs a				
	CNA 1 indicated be watched close resident would g	05 p.m., interview with a resident needed to er or needed cueing, the o into the assisted dining f could keep a closer eye				
	"Feeding Programindicated it was a used. The policy resident who has such as signiff (5) or more pour from being part of program, will go	ovided the policy, m," undated, and the policy currently being indicated, " Any special feeding needs, cant weight loss of five ads or who could benefit of a social feeding to the dining room ach and dinner to receive				
	3.1-38(a)(2)(D)					

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		IDENTIFICATION NUMBER:  15E683	A. BUILDING B. WING	00	COMPLETED 05/12/2017		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0323 SS=D Bldg. 00	(d) Accidents. The facility must e  (1) The resident ere free from accident and  (2) Each resident resupervision and as prevent accidents.  (n) - Bed Rails. The use appropriate all installing a side or rail is used, the facinstallation, use, a rails, including but elements.  (1) Assess the resentrapment from be installation.  (2) Review the risk with the resident of and obtain informer installation.  (3) Ensure that the appropriate for the	ensure that -  nvironment remains as a hazards as is possible;  receives adequate ssistance devices to .  the facility must attempt to liternatives prior to bed rail. If a bed or side cility must ensure correct and maintenance of bed a not limited to the following sident for risk of ped rails prior to the sails prio					
	record review, the staff implemente (assistive device)	tion, interview, and ne facility failed to ensure ed use of a gait belt ) to prevent an accident esident (Resident 37)	F 0323	F-323  1. THE PHYSICAL THERAPIST INSERVICED LF #1 AND DON ON USING A G.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15E683	B. WING		05/12/2017		
		ı	STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹	140 W WASHINGTON ST				
MORGAN	NTOWN HEALTH C	ARE	MORGANTOWN, IN 46160				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG	1	LSC IDENTIFYING INFORMATION)	TAG		DATE		
	during a random	observation of transfer		BELT FOR TRANSFERS OFF	•		
	care.			OF THE FLOOR.  2. ALL RESIDENTS HAVE	_		
				THE POTENTIAL TO BE	-		
	Findings include	3. 2.		AFFECTED.			
				3. ALL NURSING			
	On 5/9/17 at 0.2	9 a.m., a loud noise was		PERSONNEL WERE			
		-		INSERVICED ON 5/30/17 ON			
		ent 37 was observed		PROPER TRANSFER			
		or. LPN 1 and the		TECHNIQUES USING A GAIT			
	Director of Nursing were observed to			BELT. WILL BE MONITORE			
reach under the resident's arms and assist				BY DON OR DESIGNEE WHE EVER FALLS OCCUR.	IN		
	him up to his feet, without using a gait			4. 4. HFA, DON,OR			
belt, and walk him back to his room.				DESINGEE, CHARGE NURSI	<u> </u>		
				AND STAFF WILL MONITOR			
	On 5/12/17 at 10	0:00 a.m., Resident 37's		DAILY. THE QA COMMITTEE	≣		
		-		WILL REVIEW FOR 6 MONTH	HS.		
		vas reviewed. Diagnoses		THE FACILITY WILL FOLLOV			
	· · · · · · · · · · · · · · · · · · ·	ere not limited to:		THE RECOMMENDATIONS (	OF		
	hypertension, an	xiety, schizophrenia.		QA COMMITTEE.			
				5. DATE COMPLETED 6/11/17.			
	A review of Res	ident 37's Minimum Data		O(11/1/.			
	Set assessment,	dated 4/6/17, indicated					
	the resident was	extensive assistance with					
	transfers The Bi	rief Interview for Mental					
		vas not attempted.					
	Status (DIMS) W	vas not attempted.					
	On 5/1/0/17 + 1	0.20 a m. a marie a 6.4					
		0:30 a.m., a review of the					
	Occupational Sa	•					
		(OSHA) website:					
	https://www.osh	a.gov/ergonomics/guideli					
	nes/nursinghome	e/final_nh_guidelines.ht					
	ml, indicated the	e following regarding the					
		" For use after a fall					
		e resident for injury prior					
	_	resident can regain					
		_					
	standing position	n with minimal					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E683		A. BUILDING B. WING	6 00	COMPI	COMPLETED 05/12/2017	
NAME OF P	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST	E	
MORGAN	NTOWN HEALTH C	ARE		RGANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	handles to aid restraight, bend leg resident as possil stand with minim powered portable device to move r worn around a papurpose is to put spine of the care patient"  On 5/12/17 at 3:0 indicated if some staff would get the belt to transfer the On 5/12/17 at 3:1 Administrator incomparison.	eone was on the floor ne nurse and use a gait nem off of the floor.				
F 0328 SS=D Bldg. 00	(b)(2) Foot care. T receive proper trea maintain mobility a facility must:	RE FOR SPECIAL NEEDS o ensure that residents atment and care to and good foot health, the				
	accordance with p practice, including	e and treatment, in rofessional standards of to prevent complications medical condition(s) and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E683		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2017			
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160				
(X4) II PREFI TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	making appointment person, and arrar and from such apportunity who require colosileostomy service consistent with proparatice, the comperson-centered resident's goals at (g)(5) A resident means receives the and services to enteral feeding in aspiration pneum dehydration, metanasal-pharyngeal (h) Parenteral Flube administered of standards of prace physician orders, person-centered resident's goals at (i) Respiratory care and tracheal must ensure that respiratory care, icare and tracheal such care, consists standards of prace person-centered goals and prefere subpart.	eterostomy, or ileostomy must ensure that residents stomy, ureterostomy, or s, receive such care ofessional standards of prehensive care plan, and the nd preferences.  who is fed by enteral ne appropriate treatment . prevent complications of cluding but not limited to onia, diarrhea, vomiting, abolic abnormalities, and ulcers.  ids. Parenteral fluids must consistent with professional tice and in accordance with the comprehensive care plan, and the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COM		COMPL	ETED
		15E683	B. W	ING _		05/12/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			WASHINGTON ST		
MORGAI	NTOWN HEALTH C	CARE			ANTOWN, IN 46160		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		s a prosthesis is provided ce, consistent with					
		dards of practice, the					
		erson-centered care plan,					
		Is and preferences, to					
	wear and be able	to use the prosthetic					
	device.						
		ration, interview, and	F 0.	328	F-328		06/11/2017
	record review, th	ne facility failed to ensure					
	a resident's porta	able oxygen tank was			1. PORTABLE 02		
	filled with oxyge	en for 1 of 1 resident			CONTAINERS WITH		
	observed during	a random observations.			MALFUCTIONING GAUGES		
	(Resident 31)				WERE REPLACED. STAFF		
					WERE INSERVICED ON 5/15	5/17	
	Findings include	<b>:</b>			ON NEED TO ENSURE PORTABLE 02 CONTAINERS	3	
					ARE FULL AND FUNCTIONIN		
	On 5/4/2017 at 1	2:46 p.m., Resident 31			PROPERLY WITH EACH USE		
		the dining room pointing			2. ALL RESIDENTS HAVE		
		s chair and yelling out, "I			THE POTENTIAL TO BE AFFECTED.		
		Resident 31's portable			3. PORTABLE 02		
		s observed to be empty at			CONTAINERS ARE STORED	IN	
	that time.	s observed to be empty at			02 ROOM AND FILLED PRIO	R	
	that time.				TO GIVING TO RESIDENTS		
	On 5/0/2017 of 1	2:28 p.m., Resident 31			FOR USE. GAUGES ARE CHECKED FOR PROPER		
		* '			FUNCTIONING AS		
		ting in the dining room			CONTAINERS ARE FILLED.		
		ortable oxygen tank.			WHEN RESIDENT RETURNS		
		cated he was short of			TO THEIR ROOMS THEY AR	E	
	` ′	he nasal cannula was			PLACED ON 02		
		e resident indicated no			CONCENTRATORS AND PORTABLE 02 CONTAINERS	2	
	oxygen was com	ning out from the nasal			ARE RETURNED TO 02 ROC		
	cannula.				SO RESIDENTS CANNOT GO		
					TO LARGE DINING ROOM		
	On 5/9/2017 at 1	2:35 p.m., Certified			BEFORE PORTABLE 02	_	
	Nursing Assistar	nt 1 (CNA) indicated			CONTAINERS ARE REFILLE 4. HFA, DON OR	υ.	
	_	uently turns his oxygen			4. HFA, DON OR   DESIGNEE,CHARGE NURSE	<b>.</b>	
	1	, ,	1		525151422,511/1102 1101102	-,	1

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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION DATE			
	up to 6 liters wheempty quickly. Or refill Resident 3 at that time.  On 5/10/2017 at was observed sit with an empty per Resident 31 indinasal cannula waresident indicate from the nasal caron of Nursing (DO) Resident 31's emtank. The DON of the oxygen tank into a cup of war observed in the oxygen tank into a cup of war observed in the oxygen tank into a cup of war observed in the oxygen tank.  Resident 31's clireviewed on 5/10 Diagnoses includents.	ich causes the tank to CNA 1 was observed to 1's portable oxygen tank  10:29 a.m., Resident 31 ting in the dining room ortable oxygen tank. Cated he was SOB. The as removed and the d no oxygen was coming annula.  10:30 a.m., the Director N) was informed of apty portable oxygen was observed to pick up and put the nasal cannula are. No air bubbles were true of water which are was not working. The tank was empty d to take Resident 31 refill the portable mical record was 0/2017 at 2:50 p.m. ded, but were not limited ructive Pulmonary		STAFF WILL MONITOR DAY QA TO MONITOR FOR 6 MONTHS. THE FACILITY WILL FOLLO THE RECOMMENDATIONS THE QA COMMITTEE. 5. DATE OF COMPLET 6/11/17.	OW S OF			
		itulated order, dated d "O2 [oxygen] at 3 LPM						

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PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E683		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  00	N	(X3) DATE : COMPL 05/12/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	VIDER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[liters per minute cannula] for CO	e] per N/C [nasal PD."					
	Resident 31 indic PROBLEM/COM Resident has a di remains at risk for distress GOAI no signs/symptom distress thru next	NCERN/NEED: " agnosis of COPD and or severe respiratory L: Resident will exhibit ons of severe respiratory					
F 0371 SS=D Bldg. 00	(i)(1) - Procure foo or considered satis or local authorities (i) This may includ directly from local applicable State a regulations. (ii) This provision of prevent facilities for	E/SERVE - SANITARY  Index of from sources approved selectory by federal, state of the selector					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15E683	B. W	ING		05/12	/2017
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FROVIDER OR SUFFLIER				WASHINGTON ST		
MORGA	NTOWN HEALTH C	CARE		MORGA	ANTOWN, IN 46160		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIES		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		does not preclude nsuming foods not					
	procured by the fa	•					
	(i)(2) - Store, prepare, distribute and serve						
		e with professional					
	standards for food	i service salety.					
	(i)(3) Have a polic	y regarding use and					
	storage of foods brought to residents by						
		risitors to ensure safe and					
	sanitary storage, l consumption.	nandling, and					
		ration and interview, the	F 0	371	F-371		06/11/2017
		ensure a handwashing		,,,			00/11/2017
	_	ole for staff to use in the			l		
		time when meat was			MEAT WAS REMOVED     FROM HAND WASHING SINE		
	_	1 random observation in			MEAT WAS PLACED IN A PA		
	the kitchen.	Tundom ooservation m			WITH COLD RUNNING WATE		
	the kitchen.				AND PLACED IN THE		
	Findings include				CORRECT SINK FOR PROPE	ΞR	
	i indings include				THAWING.  2. ALL RESIDENTS HAV	F	
	On 5/10/2017 at	11:30 a.m., ten pounds			THE POTENTIAL TO BE	_	
		ed hamburger was			AFFECTED.		
		hawing in the hand			3. IN SERVICE WAS	,	
		th cold water running			CONDUCED ON 5/24/17 FOF PROPER PROCEDURE ON	•	
	1	as no hand washing sink			THAWING FOOD ITEMS AS		
		•			WELL AS THE HAND WASHI	NG	
		ff during that time. The			SINK IS ONLY FOR HAND		
		sor (DS) was observed to			WASHING. INSERVICE		
	_	office and Cook 1 was			CONDUCTED BY DIETARY MANAGER ON 5/24/2017.		
	_	reparing food for puree			POLICY FOR HAND WASHIN	IG	
	`	een ground, pressed,			SINK WAS COMPLETED AND	)	
		d to the consistency of a			FILED IN POLICY BOOK.		
	soft creamy past	e or thick liquid).			EMPLOYEE WHO PLACED	NIZ	
					MEAT IN HAND WASHING SI RECEIVED VERBAL	INT	
	On 5/12/2017 at	9:15 a.m., the DS and			COUNSILING.		
	ĺ						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>		COMPLETED				
15E683		B. WING		05/12/2017				
		l .	STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF P	PROVIDER OR SUPPLIEF	₹	140 W WASHINGTON ST					
MODGAN	MODCANTOWN HEALTH CARE							
MORGANTOWN HEALTH CARE			MORGANTOWN, IN 46160					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE			
	Cook 1 indicated they were not aware the			4. HFA, DM OR DESIGNE				
	meat could not b	be thawed in the hand		WILL MONITOR DAILY. THE				
	washing sink and they use the three compartment sink to wash their hands.			QA COMMITTEE WILL REVIE	±VV			
				FOR 6 MONTHS. THE FACILITY WILL FOLLOW THE	=			
		ik to wash then hands.		RECOMMENDATIONS OF TH				
	05/12/2017	0.26 41 -		QA COMMITTEE.	·-			
	On 5/12/2017 at			5. DATE COMPLETED				
		dicated the facility does		6/11/17.				
	not have a policy	y related to the						
	accessibility of the hand washing sink.							
	On 5/12/2017 at 9:30 a.m., a copy of the							
	Retail Food Establishment Sanitation							
	Requirement Manual 410 IAC 7-24 was							
	observed to be in the facility kitchen.							
		10:00 a.m., review of						
	the "RETAIL FOOD							
	ESTABLISHMI	ENT SANITATION						
	REQUIREMENT Manual 410 IAC							
	-	vember 13, 2004,						
		here to wash hands						
		od employees shall clean						
		hand washing sink or						
	approved automatic hand washing facility							
	and may not clea	an their hands in a sink						
	used for food pro	eparation or in a service						
	sink"							
	3.1-21(i)(2)							
	J.1 21(1)(2)							
	I		I	I .				

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NAME OF PROVIDER OR SUPPLIER  MORGANTOWN HEALTH CARE  STREET ADDRESS, CITY, STATE, ZIP CODE  140 W WASHINGTON ST  MORGANTOWN, IN 46160  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETING CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15E683			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/12/2017	
PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET)					140 W WASHINGTON ST			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION

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