STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 14, 15, 16, 17, and 18, 2016. Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census bed type: NF: 34 Total: 34 Census payor type: Medicaid: 31 Other: 3 Total: 34 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Q.R. completed by 14466 on March 28, 2016.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0221 SS=D Bldg. 00	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review, the facility failed to ensure a resident's Broda chair with straps was assessed and evaluated as the least restrictive device for 1 of 3 residents reviewed for physical restraint. (Resident #34). Findings include: On 3/14/16 at 9:47 a.m., during initial tour Resident #34 was observed in a Broda chair (recline positioning wheelchair) with her right arm hanging down to the side of the Broda chair. On 3/16/2016 at 9:42 a.m. and at 11:32 a.m., Resident #34 was observed in a Broda chair in front of the television (TV). On 3/17/2016 at 9:35 a.m. and at 2:02 p.m., Resident #34 was observed in the Broda chair in front of the TV. On 3/18/2016 at 10:00 a.m., Resident #34 was observed in a Broda chair in front of	F 0221	1. Resident #34 was re-assessed by nursing and physical therapy assessed for less restrictive device. 2. Any resident has the potential to be affected. 3. Restraint review and assessment updated quarterly in conjunction with MDS and care plans. Nursing staff were re-educated on purposes for "least restrictive" restraints and why policy and procedure must be followed on 3/30/16. Residents will be assessed by physical therapist to ensure that restraints are necessary and if so that we use the least restrictive that still ensures resident's safety. Care plans and CNA assignment sheet will be updated to address any changes. In addition Physical Therapy will review and update assessment/treatment during quarterly review. Facility will follow recommendation of Physical Therapy. 4. The FHA, DON, Charge Nurse, CNA will monitor daily. DON will report to QA Committee quarterly. Facility will follow QA Committee recommendations.	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the TV. On 3/17/2016 at 3:31 p.m., during an interview the Director of Nursing (DON) indicated an assessment was completed every quarter for the resident's Broda chair. She also indicated Physical Therapy had not assessed Resident #34 for the least restrictive device. Resident #34's clinical record was reviewed on 3/17/2015 at 2:00 p.m. The resident's diagnoses included, but were not limited to, anoxic/toxic encephalopathy (brain disease, damage or malfunction), agitation, major depression, tempro-parietal left meningioma (brain tumor). The "PHYSICAL RESTRAINT ELIMINATION EVALUATION" form, dated 10/06/2015 and 1/05/2016, both indicated the resident was not a candidate for restraint reduction or elimination program with the care plan updated. The "Action Plan" was resident may be up in the Broda chair with straps due to inability to balance self well. The "Less restrictive measures to be used" indicated the resident would slide out of the wheelchair (w/c), threw non-skid material on the floor. The "specific reason, medical symptoms or targeted behavior" was the resident would lean			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

forward and to sides, and would slide down. She also would fling her legs over the side of the chair, thrashed and flailed with poor balance due to meningioma of the brain.

The care plan, dated 10/21/14 and updated 1/5/16, indicated the problem was restraint use of the Broda chair with straps every day. The approaches included, but were not limited to, evaluate the restraint for efficacy and potential need for reduction and to review restraint use quarterly with the interdisciplinary team.

The "Use of Restraints" policy, revised on April, 2014, was provided by the DON on 3/18/2016 at 11:24 a.m. This current policy indicated the following:

"Policy Statement
Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.

Policy Interpretation and Implementation
...16. Restrained individuals shall be reviewed regularly (at least quarterly) to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	determine whether the are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination...." 3.1-3(w)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report allegations of abuse immediately to State survey and certification agency in accordance to state law and the facility's policy and procedure for 1 of 1 resident reviewed for two allegations of abuse. (Resident #7) Findings include: 1. On 3/14/2016 at 11:32 a.m., an interview with Resident #7 indicated two staff members left bruises on her right arm when they dragged her out of the bed after informing resident she was moving to another room. Resident #7 indicated she had no prior knowledge of the move and was upset and began to fight the staff members. Resident #7 indicated she did not inform staff or the administration of the allegation of abuse. On 3/14/2016 at 11:32 a.m., a bruise was observed on the upper right arm, the forearm, and the right hand for Resident #7. On 3/14/2016 at 12:00 p.m., the Administrator denied knowledge of the alleged abuse.	F 0225	1. Staff were re-educated on the importance of informing DON/HFA if any accident or incident has occurred. Staff were also re-educated on the facility's policy and procedure in regards to this matter on 3/30/16. Resident #7 had recently experienced a room change and was adjusting to that change. Behavior was monitored daily on all 3 shifts for delusions, false accusations against staff, resisting care and isolating herself. Staff followed interventions as outlined on behavior flow record. In addition, Liberty Pschy. evaluated resident #7 on 3/15/16 with no new recommendations. Psychiatrist saw resident on 3/15/16 with no new orders. 2. Any resident has the potential to be affected. 3. HFA and DON will enact an investigation when they are notified of incident to ensure policies and procedures are followed. Results of the investigation will be reported to the Indiana Department of Health per policy and appropriate action will be taken. Facility staff in-serviced regarding Facility Policy and Procedure of Incident/Accident on 4/15/16. Importance regarding timely reporting per policy by staff to	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/14/2016 at 12:02 p.m., the Director of Nursing (DON) indicated, Resident #7 was informed on more than one occasion of the move to another room and obtained the bruises to the right arm when she was fighting and hitting the staff members which is common for her to do at times. On 3/16/2016 at 10:32 a.m., the Administrator indicated he had not reported the allegation of abuse to the State Department of Health, because he had completed the investigation and did not have any findings. The Administrator was observed to ask if he needed to report it. On 3/18/2016 at 1:17 p.m., the Administrator provided the "Incident Submission" dated 3/16/2016 at 12:33 p.m., which indicated the allegation of abuse had been reported to the State Department of Health. On 3/14/2016 at 10:07 a.m., the Administrator provided the facility's current policy "Reportable Unusual Occurrences" revised 1/26/2006. The policy indicated, "Procedure: Occurrences to be reported: Facilities are required by law to report Unusual occurrences with [sic] 24 hours of		HFA and HFA to ISDH. 4. HFA and DON will monitor staff to ensure proper policy and procedure is followed daily. HFA will report to QA Committee quarterly for 6 months and will follow the recommendations of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occurrence to the Long Term Care Division ... the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries or unknown source ... are reported immediately to the administrator of the facility and to other officials in accordance with State Law ..." 2. On 3/14/2016 at 11:37 a.m., Resident #7 indicated one of the female residents was wandering in her room and laid down in her room mate's bed. The male nurse [nurses name] came in and picked her up off the bed and was very rough with her. Resident #7 indicated she did not inform staff or the administration of the allegation of abuse. On 3/14/2016 at 12:00 p.m., the Administrator denied knowledge of the alleged abuse. On 3/14/2016 at 12:02 p.m., the Director of Nursing (DON) denied knowledge of the alleged abuse. On 3/16/2016 at 10:32 a.m., the Administrator indicated he had not reported the allegation of abuse to the State Department of Health, because he had completed the investigation and didn't have any findings. The Administrator was observed to ask if he			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needed to report it. On 3/18/2016 at 1:17 p.m., the Administrator provided the "Incident Submission" dated 3/16/2016 at 12:33 p.m., which indicated the allegation of abuse had been reported to the State Department of Health. On 3/14/2016 at 10:07 a.m., the Administrator provided the facility's current policy "Reportable Unusual Occurrences" revised 1/26/2006. The policy indicated, "Procedure: Occurrences to be reported: Facilities are required by law to report Unusual occurrences with [sic] 24 hours of occurrence to the Long Term Care Division ... the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries or unknown source ... are reported immediately to the administrator of the facility and to other officials in accordance with State Law ..." 3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure implementation of their policy to report allegations of abuse to the State survey and certification agency for 1 of 1 resident reviewed for two allegations of abuse. (Resident #7) Findings include: 1. On 3/14/2016 at 11:32 a.m., an interview with Resident #7 indicated two staff members left bruises on her right arm when they dragged her out of the bed after informing resident she was moving	F 0226	1. Staff were re-educated on the importance of informing DON/HFA if any accident or incident has occurred. Staff were also re-educated on the facility's policy and procedure in regards to this matter on 3/30/16. Resident #7 had recently experienced a room change and was adjusting to that change. Behavior was monitored daily on all 3 shifts for delusions, false accusations against staff, resisting care and isolating herself. Staff followed interventions as outlined on behavior flow record. In addition, Liberty Pschy evaluated resident #7 on 3/15/16 with no new	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to another room. Resident #7 indicated she had no prior knowledge of the move and was upset and began to fight the staff members. Resident #7 indicated she did not inform staff or the administration of the allegation of abuse. On 3/14/2016 at 11:32 a.m., a bruise was observed on the upper right arm, the forearm, and the right hand for Resident #7. On 3/14/2016 at 12:00 p.m., the Administrator denied knowledge of the alleged abuse. On 3/14/2016 at 12:02 p.m., the Director of Nursing (DON) indicated, Resident #7 was informed on more than one occasion of the move to another room and obtained the bruises to the right arm when she was fighting and hitting the staff members which is common for her to do at times. On 3/16/2016 at 10:32 a.m., the Administrator indicated he had not reported the allegation of abuse to the State Department of Health, because he had completed the investigation and did not have any findings. The Administrator was observed to ask if he needed to report it.		recommendations. Psychiatrist saw resident on 3/15/16 with no new orders. 2. Any resident has the potential to be affected. 3. HFA and DON will enact an investigation when they are notified of incident to ensure policies and procedures are followed. Results of the investigation will be reported to the Indiana Department of Health per policy and appropriate action will be taken. Facility Staff in-serviced regarding Facility Policy and Procedure on Incident/Accident on 4/15/16. Importance noted regarding timely reporting per policy by staff to HFA and HFA to ISDH. 4. HFA and DON will monitor staff to ensure proper policy and procedure is followed daily. HFA will report to QA Committee quarterly for 6 months and will follow the QA recommendation of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/18/2016 at 1:17 p.m., the Administrator provided the "Incident Submission" dated 3/16/2016 at 12:33 p.m., which indicated the allegation of abuse had been reported to the State Department of Health. On 3/14/2016 at 10:07 a.m., the Administrator provided the facility's current policy "Reportable Unusual Occurrences" revised 1/26/2006. The policy indicated, "Procedure: Occurrences to be reported: Facilities are required by law to report Unusual occurrences with [sic] 24 hours of occurrence to the Long Term Care Division ... the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries or unknown source ... are reported immediately to the administrator of the facility and to other officials in accordance with State Law ..." 2. On 3/14/2016 at 11:37 a.m., Resident #7 indicated one of the female residents was wandering in her room and laid down in her room mate's bed. The male nurse [nurses name] came in and picked her up off the bed and was very rough with her. Resident #7 indicated she did not inform staff or the administration of the allegation of abuse.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/14/2016 at 12:00 p.m., the Administrator denied knowledge of the alleged abuse. On 3/14/2016 at 12:02 p.m., the Director of Nursing (DON) denied knowledge of the alleged abuse. On 3/16/2016 at 10:32 a.m., the Administrator indicated he had not reported the allegation of abuse to the State Department of Health, because he had completed the investigation and didn't have any findings. The Administrator was observed to ask if he needed to report it. On 3/18/2016 at 1:17 p.m., the Administrator provided the "Incident Submission" dated 3/16/2016 at 12:33 p.m., which indicated the allegation of abuse had been reported to the State Department of Health. On 3/14/2016 at 10:07 a.m., the Administrator provided the facility's current policy "Reportable Unusual Occurrences" revised 1/26/2006. The policy indicated, "Procedure: Occurrences to be reported: Facilities are required by law to report Unusual occurrences with [sic] 24 hours of occurrence to the Long Term Care Division ... the facility must ensure that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	all alleged violations involving mistreatment, neglect, or abuse, including injuries or unknown source ... are reported immediately to the administrator of the facility and to other officials in accordance with State Law ..." 3.1-28(a)			
F 0241 SS=E Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	or her individuality. Based on observation, interview, and record review, the facility failed to provide dignity to a resident with a catheter bag for 1 of 1 residents observed with a catheter bag (Resident #13) and failed to provide a dignified dining experience with residents sitting at the dining table for 4 out of 4 residents observed during 2 of 2 dining observations. (Resident #36, #11, #34, #19) Findings include: 1. On 3/14/2016 at 9:47 a.m., during initial tour Resident #13's catheter bag was observed from the resident's doorway. The catheter bag was observed full of yellow urine. On 3/15/2016 at 3:15 p.m., Resident #13's catheter bag was observed uncovered and was 1/2 full of yellow urine. On 3/16/2016 at 10:02 a.m., Certified Nursing Assistant (CNA) #5 indicated the facility did not have any dignity bag covers for Resident #13's catheter bag. On 3/17/2016 at 11:06 a.m., Resident #13 indicated he drank a lot of water and did not want his catheter bag covered. He	F 0241	1. Staff were re-educated on resident's rights for dignity and respect on 3/30/16. Catheter Bag now covered and trays removed from Broda chairs during dining. 2. Any resident has the potential to be affected. 3. Nursing re-educated on 4/15/16 on the proper procedure to follow when feeding residents in Broda chairs. Residents that need feeding assist that are in broda chairs will no longer use Broda chair trays when they are sitting in the dining room area. 4. DON and/or Charge Nurse will monitor nursing staff daily at meal times to ensure new practice to be followed every day. DON will report to QA Committee for 6 months and will follow the recommendations of the QA Committee. Charge Nurse and DON will monitor Catheter Bags daily and documenting on Nursing Monitoring Record. DON will report to the QA Committee for 6 months. QA will make recommendations at that time and facility will implement recommendations.	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated he wanted staff to be able to see his catheter bag as his bag would fill up frequently and needed to be emptied more than the every 2 hours when the staff generally checked it. Resident #13's clinical record was reviewed on 3/17/2017 at 2:02 p.m., The resident's diagnoses included, but were not limited to, psychosis, urostomy, and chronic back pain. The quarterly Minimum Data Set assessment, dated 2/23/16, indicated the Basic Interview Mental Status score was 15, with a score of 8 to 15 as interviewable. 2. On 3/14/16 from 11:50 p.m. to 1:00 p.m., during the dining observation Resident #36, Resident #11, and Resident #32 were observed in the assisted dining room. Each resident was observed in a Broda chair with a tray, These residents were sitting in front of the half moon table with their meals on their trays. Resident #34 was sitting to the side with her tray on a bedside table as CNA # 20 assisted to feed the resident. On 3/17/16 at 12:32 p.m., during the dining observation, Resident #36 and Resident #11 were observed in the assisted dining room. Both of these			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents were observed in their Broda chair with their meal trays served on their Broda chair's trays in front of the half moon dining room table. Resident #34 was observed to the side with her meal served on a bedside table next to her. CNA#5 was observed to assist the resident with her meal. CNA #5 was observed to ask Resident #34 if she wanted ketchup on her beans, and the resident shook her head "yes." At this same time during an interview, CNA #5 indicated she could take Resident #34's tray off and sit her next to the table where she liked to eat finger foods. On 3/17/16 at 12:50 p.m., during an interview the Director of Nursing (DON) indicated she would be afraid the residents may fall from their chairs. She also indicated she had tried it before, but indicated the residents would eat off of each others trays. No time table was given as to the last attempt with the residents eating at the dining room table. On 3/18/16 at 1:00 p.m., during an interview the DON indicated 4 residents eat in the assisted dining room for each meal. The "Resident Rights," dated 1997, was provided by the Administrator on 3/18/2016 at 3:12 p.m. This current			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	policy indicated "(a) Dignity -A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...." 3.3-3(t)			
F 0243 SS=E Bldg. 00	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. Based on record review and interview, the facility failed to ensure residents were provided the opportunity to have resident council meetings for 20 of 34 residents residing in the facility. Findings include:	F 0243	1. A meeting with all residents was conducted to re-evaluate if resident council was of interest to the residents on 3/17/16. 2. Any resident have to the Potential to be affected. 3. Results of the meeting with residents on 3/17/16 showed interest in conducting	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/17/2016 at 9:49 a.m., Resident #13 indicated the facility had Resident Council meetings around five years ago and he was the president. He indicated they would choose a special meal each month. 3/17/2016 at 10:00 a.m., during an interview Resident # 6 indicated she never heard of Resident Council meetings and did not know if she would be interested or not. On 3/17/2016 at 10:15 a.m., during an interview Resident #25 indicated the facility did not have Resident Council meeting and he would be interested. On 3/18/2016 at 1:15 p.m., the Administrator provided a facility's letterhead, dated 05/29/2012, which indicated the residents had requested no resident council meetings at this time. No resident's names were included. On 3/18/2016 at 4:08 p.m., The Social Service Director provided a list of residents presently residing in the facility who she would ask about Resident Council. This list included 20 of the residents presently residing in the facility. 3.1-3(g)		monthly resident council meetings. SSD will be re-educated regarding up-dated facility policy and procedure on 4/15/16 on resident council meetings. 4. HFA will assure that Resident Council meetings occur monthly. SSD will document monthly minutes and will report findings to QA Committee quarterly for 1 year and will follow the recommendations of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to activities designed to met a resident's needs and interest to attempt a more active participation for 1 of 3 residents reviewed for activities. (Resident #34) Findings include: On 3/14/16 at 11:45 a.m., Resident #34 was observed in bed with both eyes open. She did not respond to verbal conversation. On 3/14/16 at 3:39 p.m., Resident #34	F 0248	1. Updated Activity Assessment completed on Resident #34. Activity Director was instructed to include in resident's care plans 1 on 1 activity/interaction. Minutes spent with resident must be documented in Activity Log Book. 2. Any resident has the potential to be affected. 3. New Activity Assistant will be re-educated regarding appropriate documentation of time spent with all activities with emphasis to one to one. 4. SSD,HFA and SS Consultant will monitor to ensure that care plans are updated and proper notes are documented monthly. SSD will report to the QA Committee for 6 months and	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed in bed with both eyes closed. On 3/16/16 at 10:00 a.m., Resident #34 was observed resting in bed with both eyes closed. On 3/16/16 at 1:46 p.m., Resident #34 was observed in bed with the television on, but the resident was not positioned in bed to allow viewing of the television. On 3/17/16 at 10:13 a.m., Resident #34 was observed in bed with both eyes closed. On 3/18/2016 at 10:34 a.m., during an interview the Activity Director indicated she would do 1 to 1 activities with the residents who could not walk or wheel themselves to an activity. She indicated since Resident #34 did not speak, she would go to Resident #34 who did enjoy getting her nails done. She also indicated she would go in and talk with Resident #34, but had not tried any other type of 1 to 1 activities besides talking to her. On 3/18/2016 at 3:25 p.m., during an interview the Social Service Director indicated she completed the care plans for activities and did not think to include 1 to 1 activities as an intervention.		will follow the recommendations of the QA Committee recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #34's record was reviewed on 3/16/16 at 2:52 p.m. The resident's diagnoses included, but were not limited to, anoxic/toxic encephalopathy (brain tumor), agitation, and major depression. The activity assessment, dated 1/5/16, indicated the resident enjoyed having her nails done, sitting outside (weather permitting), and attending all parties. The resident's activity calendar attendance record for March 2016, indicated Resident #34 attended 1 to 1 activities passively on March 1, 2, 3, 4, 5, ,7, 9, 10, 11, 14, and 16. She was an active participant of the 1 to 1 activity on March 8 and 15. The "ACTIVIITY SMALLGROUP/1:1 PARTICIPATION" indicated the following: On 3/2/16 the 1 to 1 activity was indicated as passive participation with her fingernails being painted. On 3/4/16 the 1 to 1 was a small group with a passive participation. The resident did not respond when she talked to her. On 3/7/16 the resident was asleep and although she tried to talk with her she indicated the resident did not want to be disturbed. On 3/9/16 the 1 to 1 was a small group with passive participation with no response from the resident when she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	talked to her. On 3/11/16 the 1 to 1 activity was passive participation with o response to talking with the resident. On 3/14/16 the 1 to 1 activity was passive participation as she tried to visit with the resident who did not respond to her. On 3/16/16 the 1 to 1 activity was passive participation as she tried to talk with the resident but she turned her head away. She indicated she left her alone then. No further information was indicated related to any other type of 1 to 1 activity or the time spent with the resident in the resident's clinical record. 3.1-33(a)			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 27 residents reviewed for accuracy of the MDS. (Resident #9). Findings include: On 3/16/16 at 10:21 a.m., Resident #9's clinical record was reviewed. Resident #9's Minimum Data Set (MDS) assessment, dated 2/19/16, indicated, " .... Health Conditions ... Prognosis ... Does the resident have a condition or chronic	F 0278	1. All hospice residents were assessed for proper prognosis and documented accordingly, including Resident #9. New documentation now reflects prognosis of less than 6 months. 2. Any resident has the potential to be affected. 3. New physician orders were obtained to reflect the requirements for proper prognosis needed for the resident. Any residents being admitted to Hospice Services will have orders reflecting prognosis of less than 6 months. 4. HFA and DON and Charge Nurse will monitor and DON will report to QA for 6months and follow the recommendations of the QA Committee.	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disease that may result in a life expectancy of less than 6 months? ... No ... " Resident #9's Physician's Order, dated 2/12/16, indicated, "May have hospice eval et [and] tx [treatment]." On 3/18/16 at 2:52 p.m., the DON indicated she only codes the MDS if she has a physician's order indicating the resident is terminal (has less than 6 months to live). 3.1-31(d)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure staff completed a care plan for 1 of 1 resident reviewed for hospice care. (Resident #9). Findings include: Resident #9's clinical record was reviewed on 3/16/16 at 10:21 a.m. Diagnoses included, but were not limited to: congestive heart failure, coronary artery disease, and dementia. Resident #9's current care plan, dated 1/5/15 indicated, "Code Status has been designated as NO CODE ... INTERVENTION: 2/12/16 -May have hospice eval (evaluation) and tx (treatment) admit to (hospice)." The care plan did not address specific interventions related to hospice care. On 3/18/16 at 2:38 p.m., the DON (Director of Nursing) indicated, the "NO CODE," care plan was used as reference	F 0279	1. Resident's Care Plan was updated to address hospice intervention. 2. Any resident has the potential to be affected. 3. DON reviewed Hospice requirements. DON will create new Hospice Care Plan when resident admitted to Hospice, and updated current Hospice Resident #9. 4. DON, MDS Coordinator, Charge Nurse and HFA will monitor. DON will report to QA for 6 months and will follow the recommendations of the QA Committee.	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for hospice care and there were no additional care plans related to hospice care for Resident #9. On 3/18/16 at 3:39 p.m., the Administrator provided the facility's policy, "Plan of Care Assessments," undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Each resident shall have a Plan of Care so that he/she will receive the care necessary to enable him/her to achieve and/or maintain the highest practical physical, mental and psychological well-being ..." 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure staff implemented a care plan fall prevention intervention for 1 of 4 residents reviewed for accidents.	F 0282	1. Resident re-assessed and care plan updated to reflect resident's choice to wear no shoes and regular socks.2. Any resident has the potential to be affected.3. All nursing staff re-educated on 3/30/16 to follow updated care plan. Resident has	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Resident #19). Findings include: On 3/16/16 at 9:46 a.m., Resident #19 was observed to push a rolling walker in the hallway without non-skid socks. On 3/16/16 at 11:13 a.m., Resident #19 was observed to walk in the hallway without non-skid socks. On 3/16/16 at 1:17 p.m., Resident #19 was observed to push a rolling walker in the hallway without non-skid socks. On 3/17/16 at 10:54 a.m., Resident #19 was observe to push a rolling walker in the hallway without non-skid socks. On 3/18/16 at 10:09 a.m., Resident #19's clinical record was reviewed. Resident #19's current care plan, dated 2/17/16, indicated, "Resident has multiple risk factors for falls such as hx (history) of falls ... Intervention ... 4. Use shoes or footwear with non-skid soles ... " On 3/17/16 at 2:12 p.m., the Certified Nursing Assistant (CNA) #2 indicated Resident #19 is very independent, does not like to wear shoes, and only wears		not sustained any falls.4. DON and Charge Nurse will monitor and DON will report to QA Committee for 6 months and facility will follow the recommendations of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	socks without non-skid soles. On 3/18/16 at 3:23 p.m., the Director of Nursing (DON) indicated Resident #19 has new shoes, but she refuses to wear them and she does not have any documentation which indicated the resident refuses to wear non-skid socks. On 3/18/16 at 3:39 p.m., the Administrator provided the facility's policy, "Plan of Care Assessments," undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Each resident shall have a Plan of Care so that he/she will receive the care necessary to enable him/her to achieve and/or maintain the highest practical physical, mental and psychological well-being ..." 3.1-35(g)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and	F 0323	1. Nursing Staff were re-educated on following care plan Fall Prevention Methods on	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record review, the facility failed to ensure staff ensure implementation of a fall prevention intervention for 1 of 4 residents reviewed for accidents. (Resident #19). Findings include: On 3/16/16 at 9:46 a.m., Resident #19 was observed to push a rolling walker in the hallway without non-skid socks. On 3/16/16 at 11:13 a.m., Resident #19 was observed to walk in the hallway without non-skid socks. On 3/16/16 at 1:17 p.m., Resident #19 was observed to push a rolling walker in the hallway without non-skid socks. On 3/17/16 at 10:54 a.m., Resident #19 was observe to push a rolling walker in the hallway without non-skid socks. On 3/18/16 at 10:09 a.m., Resident #19's clinical record was reviewed. Resident #19's current care plan, dated 2/17/16, indicated, "Resident has multiple risk factors for falls such as hx (history) of falls ... Intervention ... 4. Use shoes or footwear with non-skid soles ... "		3/30/16. 2. Any resident has the potential to be affected. 3. All nursing staff re-educated on 3/30/16 to follow updated care plan. Resident has not sustained any falls. 4. DON and Charge Nurse will monitor and DON will report to QA committee for 6 months and facility will follow the recommendation of the QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/17/16 at 2:12 p.m., the Certified Nursing Assistant (CNA) #2 indicated Resident #19 is very independent, does not like to wear shoes, and only wears socks without non-skid soles. On 3/18/16 at 3:23 p.m., the Director of Nursing (DON) indicated Resident #19 has new shoes, but she refuses to wear them and she does not have any documentation which indicated the resident refuses to wear non-skid socks. On 3/18/16 at 3:39 p.m., the Administrator provided the facility's policy, "Plan of Care Assessments," undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Each resident shall have a Plan of Care so that he/she will receive the care necessary to enable him/her to achieve and/or maintain the highest practical physical, mental and psychological well-being ..." 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure the Medical Doctor (MD) provided a rationale for declining a Gradual Dose Reduction (GDR) for a resident on an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medication use (Resident #36) and failed to ensure residents who received a psychotropic medication were monitored for targeted behaviors and for effectiveness of medications for 2 of 5 residents reviewed for unnecessary medication use. (Resident #11, Resident #23). Findings include: 1.) The clinical record was reviewed for Resident #36 on 3/18/2016 at 11:30 a.m.	F 0329	1. Nursing Staff and Psychiatrist were re-educated on the facility policy regarding gradual dose reduction on 4/12/16. Resident 23 was re-evaluated and due to no current behaviors physician ordered anti-psychotic to be discontinued. Resident 11 was evaluated and psychiatrist made no new order changes due to previously failed attempt in dose reduction. 2. Any resident has the potential to be affected. 3. Any pharmacy consultation GDR reports will be reviewed by Psychiatrist and DON. DON re-educated License Nursing Staff on 3/30/16 of correct documentation to monitor for behaviors for residents on anti-psychotic drugs. 4. HFA and DON will monitor and report to QA Committee for 6 months and	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Diagnoses included, but were not limited to dementia with behavioral disturbance. The current physician orders dated March 2016, indicated Resident #36's received risperidone (an antipsychotic) 0.25 milligrams (mg) two times a day for dementia with behaviors. The start date was 9/24/2015. On 3/18/2016 at 1:00 p.m., the Administrator provided the "Consultation Report" dated December 23, 2015 through December 23, 2015, for Resident #36's risperidone. The report indicated a pharmacist had reviewed Resident #36's medications and recommended, "...if appropriate consider reduction of risperidone to 0.25 mg at HS [bedtime]." The Medical Doctor (MD) declined a GDR for the risperidone and did not provide patient specific rationale describing why a GDR attempt is likely to impair function or increase behavior in Resident #36. On 3/18/2015 at 3:59 p.m., the Director of Nursing (DON) indicated the MD usually does document a rationale for why he is refusing the GDR and he should have put a rationale for why he is refusing to decrease Resident #36's risperidone.		will follow the recommendations of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/18/2016 at 3:31 p.m., the Administrator provided the facility policy "Gradual Dosage Reductions (GDR) undated, and indicated it was the one currently being used by the facility. The policy indicated, " ... if a GDR is deemed clinically contraindicated the prescriber must document the clinical rationale for why additional attempted dose reduction at that time would likely impair the resident's function or cause psychiatric instability by exacerbating medical or psychiatric disorder ..." 2.a.) The clinical record was reviewed for Resident #11 on 3/18/15 at 11:14 a.m. Diagnoses included, but were not limited to: dementia with behavioral disturbance, sexual aggression, anxiety, agitation, depression, and psychosis. The physician's March 2016, orders for Resident #11 indicated the following: On 5/14/15, the resident was ordered mirtazapine (antidepressant medication) 15 mg (milligrams) at bedtime. On 8/11/15, the resident was ordered Risperdal (antipsychotic medication) 12.5 mg every 2 weeks. On 11/21/15, the resident was ordered Lorazepam (antianxiety medication) 20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mg two times daily. On 11/24/15, the resident was ordered paroxetine (antidepressant medication) 30 mg daily. The clinical record lacked documentation which indicated targeted behaviors for which the medication was prescribed were daily monitored for Resident #11's mirtazapine, paroxetine, nor Risperdal. The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for risperidone included: "Fatal CV (cardiovascular) or infectious adverse events may occur in elderly patients with dementia. Drug isn't safe or effective in these patients." On 3/18/16 at 3:45 p.m., the DON (Director of Nursing) indicated staff charts by exception in regard to behavior monitoring and they begin a Behavior Flow Record after a resident displays a behavior. On 11/17/15 at 3:08 p.m., the DON provided the facility's policy, "Behavior Management Policy and Procedure," updated on August, 2015, and indicated it was the policy currently being used by the facility. The policy did not address daily monitoring for targeted behaviors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	related to psychotropic medication use. 2.b.) The clinical record was reviewed for Resident #23 on 3/18/15 at 2:34 p.m. Diagnoses included, but were not limited to: major depressive disorder and insomnia. The physician's March 2016, orders for Resident #23 indicated the following: On 2/18/16, the resident was ordered Nuedexta (antipsychotic medication) 20-10 mg twice daily, quetiapine (antipsychotic medication) 25 mg every evening, and sertraline 100 mg at bedtime. The clinical record lacked documentation which indicated targeted behaviors for which the medication was prescribed were daily monitored for Resident #23's Nuedexta, quetiapine, nor sertraline. The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for quetiapine included: "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV (cardiovascular) disease or infection." On 3/18/16 at 3:45 p.m., the DON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Director of Nursing) indicated staff charts by exception in regard to behavior monitoring and they begin a Behavior Flow Record after a resident displays a behavior. Since Resident #23 had not displayed a behavior yet, they have not began to monitor him for behaviors. On 3/18/16 at 3:31 p.m., the Administrator provided the facility's policy, "Resident Behavior and Facility Practice Policy," undated, and indicated it was the policy currently being used by the facility. The policy did not address daily monitoring for targeted behaviors related to psychotropic medication use. 3.1-48(a)(3) 3.1-48(b)(2)			
F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview, observation, and	F 0412	1. SSD contacted the dental service to schedule a follow up	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record review, the facility failed to follow up for re-evaluation of a resident's partial plates for 1 of 1 resident reviewed for dental care. (Resident #20) Findings include: On 3/17/16 11:03 a.m., during an interview Resident #20 indicated his upper partials no longer fit and he would need a new pair. He indicated his upper partial was sitting in a bag behind his television, which was observed. On 3/17/16 at 2:00 p.m., the Social Services Director (SSD) indicated she was aware Resident #20 had recently received upper and lower partial plates and had not checked with the resident to see if there were any problems. She indicated she would check with the dental service. On 3/17/2016 at 3:15 p.m., the SSD indicated after contacting the dental service, the dental service was checking on the resident's pay source for the repair work, and he would be seen for fitting of the partial plates at the end of this month as this had been "missed." Resident #20's clinical record was reviewed on 3/17/16 at 12:08 p.m. The resident's diagnoses included, but were		appointment for the repair. 2. Any resident has the potential to be affected. 3. SSD contacted the dental service to schedule an appointment for the repairs to the dentures. SSD will also document when residents receive partials and follow up documentation that residents are pleased with the services they receive. Nursing Staff and SSD will monitor residents to ensure outside resources provided proper care. If residents are not pleased with services then documentation will be recorded and a follow up appointment will be scheduled for the resident. DON and/or SSD will contact provider for appropriate services. 4. HFA, DON, Charge Nurse,SSD will monitor daily and or weekly. SSD will report to QA committee for 6 months and facility will follow the QA Committee recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not limited to, schizophrenia, poor vision, hypertension, and debility. The quarterly Minimum Data Set assessment, dated 2/2/16, indicated the Basic Interview Mental Status score was 15, with a score of 8 to 15 as interviewable. The consult dental service, dated 2/25/16, indicated the repaired partial plates were delivered with a replacement of tooth #7 and adjustment of the plates. 3.1-24(a)			
F 0460 SS=D Bldg. 00	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Based on observation and interview, the facility failed to provide full privacy for residents in their room for 3 rooms	F 0460	1. ESD measured curtains and placed and order for new curtains.2. Any resident has the potential to be affected.3. HFA	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed. (Room #3, #5, and #24) Finding include: 1.) On 3/14/16 at 3:12 p.m., in Room 5 the privacy curtain was observed to be short when pulled around the resident's bed. In Room 5, one privacy curtain was indicated to be 36 inches short, and a second one was 72 inches short. On 3/18/16 from 9:25 a.m. to 10:05 a.m., with the Housekeeping Supervisor the following was observed: 2.) In Room 3 the privacy curtain was 36 inches short to provide full privacy. The bed could be observed as one opened the room door. The bed by the window was indicated to be 48 inches short for full coverage. 3.) In Room 24, there was no curtain at the end of the bed across from the residents closets. At this same time, during an interview the Housekeeping Supervisor indicated residents resided in the beds with the short/missing privacy curtains.		in-serviced ESD regarding proper fit of privacy curtains and importance of Maintaining a supply to meet needs of residents.4. ESD, HFA and DON will monitor daily nursing staff to ensure proper procedures are being followed when providing care to residents that require privacy. ESD to report to QA committee for 1 year and facility will follow the QA recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(l)(6)			
F 0516 SS=B Bldg. 00	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation, interview and record review, the facility failed to protect and secure the medical records. (3/14/16)	F 0516	1. Staff immediately reminded to close and lock door when leaving medical records office.2. Any resident has the potential to be affected.3. The Facility will install a self-closing door with	04/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: On 3/14/2016 at 9:35 a.m., the medical record room was observed with the door unlocked with no one present in this room. Twelve files were observed on top of the metal cabinets. One of these files was observed for Resident #42 who had been admitted on 3/17/14 and had passed away on 1/13/16. A sprinkler system was observed in this room. On 3/14/2016 at 9:50 a.m., the Maintenance Supervisor indicated he needed to lock the room as it should be locked when no one was present. On 3/14/2016 at 2:05 p.m., the Medical Records assistant indicated she was to lock the door when she left the room. She also indicated the 12 files on the top of the metal cabinets were discharged residents. On 3/15/16 at 11:20 a.m., during an interview the Director of Nursing (DON) indicated she did not know how the charts would be protected if the sprinkler system was activated. On 3/18/2016 at 11:24 a.m., the DON provided a list of 4 wandering and mobile residents in the vicinity of the medical record room.		self-locking doorknob to ensure the medical records are properly secured. When the staff is not currently working on a record then the record will immediately be placed back into the medical records file cabinet.4. HFA, DON, ESD will monitor daily and report to QA committee for 6 months and facility will follow the recommendations of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The "Location and Storage of Medical Records" policy, dated December 2006, was provided by the DON on 3/18/2016 at 11:47 a.m. This current policy indicated the medical records were to be stored in a locked room and protected from fire, water damage, insects, and theft. 3.1-50(d)			