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	09/09/2015

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 the Investigation of Complaint IN00181292. Complaint IN00181292 - Substantiated. Federal/State deficiencies related to allegations are cited at F223. Survey date: September 9, 2015 Facility number: 000399 Provider number: 155750 AIM number: 100289100 Census bed type: SNF/NF: 35 Total: 35 Census payer source: Medicaid: 34 Other: 1 Total: 35 Sample: 03 Morgantown Health Care was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the investigation of Complaint IN00181292. This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	QR completed by 14466 on September 15, 2015.			
F 0223 SS=A Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident would be free from being hit for 1 of 1 resident reviewed for abuse. (Resident#A) Findings include: The clinical record for Resident #A was reviewed on September 9, 2015 at 1:30 p.m. The diagnoses included, but were not limited to: vascular dementia with/delusions and diabetes. The quarterly MDS (Minimum Data Set) assessment completed on 8/15/15, assessed Resident #A to need extensive assistance with ADL's (activities of daily	F 0223	1. Resident was assessed for any injuries. Dr. was contacted immediately and no new orders were obtained at that time. Employee was suspended on 8/28/15. 2. All residents have the potential to be affected. 3. SSD will re-educate all residents monthly X 6 to report any alleged abuse to the HFA,DON, SSD, Charge Nurse or Staff on any day of the week (7 days). All staff re-educated on Abuse and Resident Rights on Aug. 31, 2015 at 1:00p.m. Facility will continue to investigate all accusations of Abuse and report to the DON or the Administrator as well as the State Board of Health on any day, all shifts.Abuse policy was reviewed and dated. Charge Nurse on all shifts, seven day a	10/09/2015

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	living). A BIMS (Brief Initial Mental Status), dated 8/15/15, was noted to be a 99 (unable to conduct interview). On 9/9/15 at 11:00 a.m., interview with LPN #1 indicated they (staff) were working the day of the alleged abuse. They indicated they heard the social service person bring Resident #A down from activities, due to needing to use the restroom. CNA #1 was over heard making a one word curt response of " 'really,' " but took Resident #A into the shower room without incident. A few minutes later, yelling was heard from the shower room. CNA #2 went in to the shower room to assist and then both CNA #1 and CNA #2 wheeled Resident #A to their room. LPN #1 followed. Upon seeing Resident #A, LPN #1 noticed red marks on Resident #A's neck (right side) and when questioned, Resident #A indicated they didn't want to say anything. CNA #2, who was still in the room, advised LPN #1 that CNA #2 witnessed CNA #1 hit Resident #A on the side of the neck, because Resident #A was yelling and swinging at CNA #1. LPN #1 did a full assessment on Resident #A, did not find anything other concerns, made sure Resident #A was safe, then went and reported incident to Administrator who suspended CNA #1 immediately.		week will sign off that any alleged abuse has been reported by Staff or Resident and that Charge Nurse has reported to HFA, DON, SSD. HFA and DON, SSD will sign off daily that there have been no reports of alleged Abuse. The facility will continue to screen all new employees, including reference checks (2) and obtaining a criminal history check on all new employees. The facility conducts yearly in-service training including Abuse. In addition this topic is covered in great detail during Dementia Training that is presented twice a year, and then as needed throughout the year. The facility attempts prevention by making sure employees take their breaks, vacations, lunch periods and time off when requested. The facility administrator and DON operate with a open door policy so that staff feel free to communicate any concerns at anytime. The staff is trained to recognize signs and symptoms of abuse in each in-service. In-servicing is conducted monthly always ending with open answer and question period. The facility will continue to investigate and report all alleged abuse per facility policy that has been reviewed and updated. The facility will attempt to protect the resident by following the above protocol, reviewing the abuse policy with each new employee during orientation and having them sign the policy and this will	

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	Interview with the Administrator, on 9/9/15 at 11:30 a.m., indicated the DON (Director of Nursing) was out of the building at the time of the incident and when she returned a further investigation was made of the incident. Recounts of incident were obtained from LPN #1 and CNA #2, and that physical abuse was determined to have occurred. CNA #1 was terminated on 8/31/2015, and an inservice on resident rights and abuse was given on August 31, 2015 at 1:00 P.M. On 9/9/15 at 10:15 a.m., the Administrator provided the facility policy of incidents of alleged abuse, not dated, and indicated the policy was current. Review of the policy indicated, "...abuse is the willful infliction of injury resulting in physical harm." Facility incident documentation indicated CNA #1 was terminated due to validating abuse had occurred, due to the statement of LPN #1 indicating Resident #A had red streaks on the right side of their neck (willful infliction of injury). This Federal tag relates to Complaint IN00181292. 3.1-27(b)		be placed in their personnel file, social service designee to conduct daily visits giving each resident opportunity to report any concerns, staffing adequately to meet the needs of the resident, and continue to train staff to be attentive to each resident's needs, physical and psycho-social. The facility will report incidents following the guidelines as presented by ISDH. Staff is trained in the abuse policy how to report any indications, verbal reports, and signs and symptoms of abuse to the Administrator, DON and/or their immediate supervisor. Department Managers, HFA,DON,Charge Nurse, SSD, AD,CNA,all staff and S.S. Consultant will monitor seven days and report to QA Committee for one year, completed 9/29/2015. 4. H.F.A.,DON,SSD as well as Staff will monitor Daily. The QA Committee will review for one year. The facility will follow the recommendations of the QA Committe. 5. Date Completed 10/9/2015.	

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