STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING -- B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN HEALTH CARE	140 W WASHINGTON ST MORGANTOWN, IN 46160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/29/23 Facility Number: 000399 Provider Number: 15E683 AIM Number: 100289100 At this Emergency Preparedness survey, Morgantown Health Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 39 certified beds. At the time of the survey, the census was 33. Quality Review completed on 08/30/23	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DALE W. HARTMAN	HFA	09/26/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to maintain an emergency preparedness	E 0004	1. ADM SIGNED THE DOCUMENT	09/11/2023

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	plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparedness" documentation dated 09/20/21 with the Administrator during record review from 10:20 a.m. to 12:40 p.m. on 08/29/23, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 09/20/21 which was not within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated he reviewed the plan last week, but forgot to date the review sheet. The Administrator signed and wrote 08/29/23 on the Disaster Preparedness review sheet at the time of record review. This finding was reviewed with the Administrator during the exit conference.		IMMEDIATELY ON 8/29/2023 IN FRONT OF LIFE SAFETY SURVEYOR. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADM , ENVIRONMENTAL SUPERVISOR WILL REVIEW THE EMERG. PREPARDNESS BOOK FOR SIGNATURES TWICE A YEAR , JANUARY AND JULY. 4. ADM WILL REPORT TO QAPI AT THE NEXT QAPI MEETING AND FACILIY WILL FOLLOW QAPI RECOMMENDATIONS FOR 6 MONTHS 5. DATE COMPLETED 09/11/23.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

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	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,			

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	15E683	A. BUILDING -- B. WING	08/29/2023

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	and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review on 08/29/23 between 10:20 a.m. and 12:40 p.m. and 1:27 p.m. to 2:30 p.m., no documentation could be found regarding a documented facility-based and community-based	E 0006	1. THE FORM WAS COMPLETED 8/29/23 FOR THE FACILITY-BASED AND COMMUNITY - BASED RISK ASSESSMENT. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADMIN WILL REVIEW THE NEEDS OF THE FACILITY YEARLY AND MAKE ANY CHANGES THAT ARE NEEDED FOR MORGANTOWN HEALTH	09/11/2023

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	risk assessment utilizing an all-hazards approach. Based on interview at the time of record review, the Administrator stated a risk assessment utilizing an all-hazards approach had never been asked for before and one is not in the Disaster Preparedness binder. This finding was reviewed with the Administrator at the time of discovery and during the exit conference.		AND THE PROTECTIONS FOR STAFF AND RESIDENTS AS NEEDED. 4. ADMIN WILL REPORT IT TO QAPI AT THEIR NEXT MEETING AND THE RECOMMENDATIONS OF QAPI WILL BE FOLLOWED FOR SIX MONTHS. 5. DATE COMPLETED 09/11/23	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must			

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	develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2			

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	years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID). The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparednessl" documentation dated 09/20/21 with the Administrator during record review from 10:20 a.m. to 12:40 p.m. on 08/29/23, emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 09/20/21 which was not within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated he reviewed the plan last week, but forgot to date the review sheet. The Administrator signed and wrote 08/29/23 on the Disaster Preparedness review sheet at the time of record review. This finding was reviewed with the Administrator at the time of discovery and during the exit conference.	E 0013	1. A REVIEW OF THE EMERGENCY BOOK WAS IMMEDIATELY REVIEWED ON 8/29/23 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADMIN, ENVIRONMENTAL WILL REVIEW EMERGENCY BOOK TWICE A YEAR (JAN. JULY) TO MAKE SURE THAT THE POLICIES AND PROCEDURES A DONE AND ALL HAVE BEEN REVIEWED . 4. ADMIN WILL REPORT TO QAPI AT THEIR NEXT MEETING AND THE FACILITY WILL FOLLOW THE RECOMMENDATIONS FOR SIX MONTHS. 5. DATE COMPLETED 09/11/23	09/11/2023
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c),			

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	485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the "Disaster Preparedness" dated 09/20/21 on 08/29/23 from 10:20 a.m. to 12:40 p.m., the Disaster Preparedness binder did not include a written communication plan. Based on an interview with the Administrator on 08/29/23, he stated a Communication Plan has never been asked for before and was unable to provide a communication plan at the time of the survey. This finding was reviewed with the Administrator at the time of record review and exit conference.	E 0029	1. A PLAN OF COMMICATION WAS ESTABLISHED FOR THE FACILITY, 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADMIN WILL REVIEW THE THE CURRENT PLAN OF COMMUNICATIN TO MAKE SURE THAT THE CURRENT COMMUNICATION IS CURRENT AND IF ANY CHANGE IS NEED YEARLY OR IF SOME CHANGES ARE NEED THROUGH OUT THE YEAR. 4. ADMIN WILL REPORT TO NEXT QAPI MEETING AND THE	09/11/2023

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			FACILITY WILL FOLLOW THEIR RECOMMENDATIONS FOR SIX MONTHS. \ 5. DATE COMPLETED 09/11/23	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the			

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	actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or			

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	15E683	A. BUILDING -- B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN HEALTH CARE	140 W WASHINGTON ST MORGANTOWN, IN 46160

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	(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed			

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	to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise			

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	the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			

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	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator	E 0039	1. AN IN-SERVICE WAS IMMEDIATELY SCHEDULED FOR OCTERBER 16.2023. THE SECOND EXERCISE IS SCHEDLED FOR OCTOBER 16,2023 AT THE FACILITY WHICH WILL BE A TABLE TOP EXERCISE. 2, ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADMIN HAS SCHEDULED AND IN SERVICE FOR 10;16/23, AN ACTION REPORT SHALL BE WRITTEN AFTER THE IN-SERVICE IS COMPLETE AS WELL ON THE ONE FOR 3/31/23 4. ADMIN WILL REPORT TO QAPI AT THEIR NEXT MEETING AND FACILITY WILL FOLLOW THE RECOMMEDATION OF QAPI FOR SIX MONTHS. 5. DATE COMPLETED 09/11/23	10/16/2023

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	on 08/29/23 from 10:20 a.m. to 12:40 p.m., documentation for a facility based exercise conducted on 03/31/23 was incomplete. There was no after action report included to analyze the facility's response to the exercise. Additionally, no documentation of a second exercise of choice could be provided at the time of record review. Based on interview at the time of record review, the Administrator stated a second exercise had not been conducted and one is planned for October and no additional documentation was available to review. This finding was reviewed with the Administrator during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/29/23 Facility Number: 000399 Provider Number: 15E683 AIM Number: 100289100 At this Life Safety Code survey, Morgantown Health Care was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was	K 0000		

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	determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 39 and had a census of 33 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered. Quality Review completed on 08/30/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 linen room which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 10 residents and staff in the vicinity of the linen room by the nurse station. Findings include: Based on observations during a tour of the facility with the Environmental Services Director on 08/29/23 at 1:10 p.m., the linen room; a hazardous storage room containing combustible storage and was greater than 50 square feet; was equipped with a self-close device but failed to latch when tested three times. Based on interview at the time of observation, the Environmental Services Director agreed the room was used as storage, was larger than 50 square feet and the self closing door failed to latch when tested. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0321	1. MAINTENANCE IMMEDIATELY ADJUSTED THE LINEN ROOM DOOR CLOSURE SO THAT IT COMPLETELY CLOSED AND LATCHED WHEN SHUT ON AUGUST 30,2023 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. MAINTENANCE WILL CHECK DOORS DAILY AS IS ON THE DAILY CHECK LIST AND MAKE SURE THE DOORS ARE CLOSING AND LATCHING PROPERLY. ADJUSTMENTS WILL BE MADE IF NEEDED TO ASSURE DOORS ARE CLOSING PROPERLY. AN INSERVICE WITH MAINTENANCE AND SUPERVISOR WAS CONDUCTED ON SEPTEMBER 7TH 2023 WITH REVIEW OF DAILY CHECK LIST AND DOCUMENTATION.	09/11/2023

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			4. ADMIN WITH REPORT WITH QAPI AT THE NEXT MEETING AND FACILITY WILL FOLLOW RECOMMENDATIONS OF QAPI FOR 6 MONTHS. 5. DATE COMPLETED 09/11/23	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to	K 0353	1. MAINTENANCE IMMEDIATELY CHECKED THE SPRINKLER GAUGES IN THE BASEMENT AND DOCUMENTED IT ON THE DAILY MAINTENANCE CHECK LIST.	09/11/2023

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	ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on record review of "Weekly Sprinkler Gauge and Valve Check" documentation for the most recent twelve month period with the Environmental Services Director during record review from 10:20 a.m. to 12:40 p.m. on 08/29/23, weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available for review. Monthly dry sprinkler system valve inspection documentation for 8 months of the most recent 12 month period was also not available for review. The facility's quarterly dry sprinkler system inspections were conducted on 07/14/23, 04/28/23, 01/3023 and 10/05/22 and the two gauge pressures are documented on the inspection tags at the riser. Based on interview at the time of record review, the Environmental Services Director confirmed that weekly dry sprinkler system gauge pressures and control valve inspection documentation for the aforementioned weekly and		2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADM AND ENVIRONMENTAL SUPERVISOR AND MAINTENANCE WILL CHECK DAILY TO MAKE SURE THE SPRINKLER GAUGE IS CHECKED DAILY AND THE DOCUMENTATION IS UP TO DATE. INSERVICE WAS COMPLETED ON SEPTEMBER THE 7TH 2023 4. QAPI WILL BE NOTIFIED ON THE NEXT MEETING AND WILL FOLLOW RECOMMENDATIONS OF QAPI FOR 6 MONTHS 5. DATE COMPLETED 09/11/23	

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	monthly periods was not available for review. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			

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	15E683	A. BUILDING 01 B. WING	08/29/2023

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	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 20 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observation with the Environmental Services Director on 08/29/23 during a tour of the facility at 12:59 p.m., the corridor door to resident room 26 did not latch into the frame when tested. Based on interview at the time of observation, the Environmental Services Director agreed the corridor door would not latch into the door frame and would have the Maintenance man work on the door. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0363	1. MAINTENANCE IMMEDIATELY ADJUSTED THE DOOR LATCH SO THAT IT COMPLETELY CLOSED. ALL DOORS WERE CHECKED TO MAKE SURE THEY ALL CLOSED PROPERLY. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3 ADM , ENVIRONMENTAL AND MAINTENANCE WILL CHECK WEEKLY TO MAKE SURE THE DAILY DOOR CHECKS ARE DONE ON THE MAINTENANCE LIST. AN INSERVICE WAS COMPLETED ON SEPTEMBER 7TH 2023 GOING OVER THE DOCUMENTATION. 4, QAPI WILL BE NOTIFIED AT NEXT MEETING AND FACILITY WILL FOLLOW THE	09/11/2023

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			RECOMMENDATIONS OF QAPI FOR 6 MONTHS 5. DATE COMPLETED 09/11/23	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Record" form with the Environmental Services Director on 08/29/23 between 10:20 a.m. to 12:40 p.m., there was no documentation for a third shift fire drill in the fourth quarter of 2022. Based on interview at the time of record review, the Environmental Services Director confirmed that the fire drills was missing and stated that the third shift fire drill was not conducted. This finding was reviewed with the Administrator	K 0712	1.A YEARLY CALENDAR WAS IMMEDIATELY PUT IN EFFECT TO TRACK YEARLY AND QUARTERLY FIRE DRILLS SO THEY CAN BE CONDUCTED IN A TIMELY MANNER 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADM , ENVIRONMENTAL SUPERVISOR AND MAINTENANCE WILL CHECK QUARTERLY TO MAKE SURE ALL FIRE DRILLS ARE COMPLETED AND UP TO DATE.	09/11/2023

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	at the exit conference. 3.1-19(b) 3.1-51(c)		4. QAPI WILL BE NOTIFIED AT NEXT MEETING AND THEIR WILL BE FOLLOWED BY FACILITY FOR 6 MONTHS. 5. DATE COMPLETED 09/11?23	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 20 resident room corridor doors contain decorations that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is	K 0753	1. MAINTENANCE IMMEDIATELY REMOVED DOOR DECORATIONS FROM RESIDENT ROOM DOOR #23. NURSING AND SOCIAL SERVICE WERE REMINDED TO INFORM RESIDENTS FAMILY TO NOT COVER RESIDENT ROOM DOORS. NO MORE THAN 20%	09/11/2023

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	applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Environmental		OF DOORS CAN BE COVERED. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3 MAINTENANCE WILL CHECK DOORS ON A DAILY BASIS TO MAKE SURE DOORS ARE FREE OF OVER DECORATION PER HIS DAILY CHECK LIST. AN INSERVICE ON SEPTEMBER 7TH 2023 WITH MAINTENANCE AND ENVIRONMENTAL SUPERVISOR TO GO OVER MAINTENANCE DOCUMENTATION ON HIS DAILY LIST. 4. QAPI WILL BE NOTIFIED AT NEXT MEETING AND FACILITY WILL FOLLOW RECOMMENDATIONS OF QAPI FOR 6 MONTHS 5, DATE COMPLETED 09/11/23	

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	Services Director on 08/29/23 at 1:01 p.m., the corridor door of resident room 23 contained wrapping paper decorations and artificial flowers that covered 100% of the door. Based on interview at the time of the observation, the Environmental Services Director agreed the corridor door was covered with a combustible decoration and stated it was 100% covered. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and			

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	results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure complete documentation was available for all nonhospital-grade electrical receptacles in all resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on record review on 08/29/23 between 10:20 a.m. and 12:40 p.m. with the Environmental Services Director, there was no complete documentation available of an annual resident room receptacle test for non hospital-grade receptacles. There was one sheet dated 08/24/23 with room numbers 1L and 2L and their itemized receptacles, however no testing results were documented. An additional undated sheet with room name 1BTC had results and 'broken replaced' in corrective action column. Based on interview at the time of record review, the Environmental	K 0914	1. MAINTENANCE IMMEDIATELY FINISHED HIS RECEPTACLE CHECKS AND DOCUMENTATION ON AUGUST 30TH 2023 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. ADM , ENVIRONMENTAL AND MAINTENANCE WILL CHECK YEARLY TO MAKE SURE THE RECEPTACLE TEST ARE COMPLETED YEARLY. AND THAT THE DAILY CHECKS ON RECEPTACLES ARE DOCUMENTED. AN INSERVICE WAS COMPLETED ON SEPEMBER 7TH 2023 REVIEW OF DOCUMENTATION. 4. QAPI WILL BE NOTIFIED AT NEXT MEETING AND FACILITY WILL FOLLOW QAPI RECOMMENDATIONS FOR 6 MONTHS 5. DATE COMPLETED 09/11/23.	09/11/2023

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	Services Director stated the Maintenanc man tested all the receptacles last week and they all work, and agreed that completed receptacle retention for the annual testing was not available for review. Based on observations on 08/29/23 between 12:40 p.m. and 1:25 p.m. during a tour of the facility with the Environmental Services Director, there were at least four electrical receptacles in each resident room. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)			