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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 7, 8, and 9, 2025 Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census Bed Type: NF: 35 Total: 35 Census Payor Type: Medicaid: 34 Other: 1 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 15, 2025.	F 0000	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and citations listed on this statement of deficiencies. This plan of correction shall operate as Morgantown Woods of Journey's written credible allegation of compliance. Morgantown Woods of Journey respectfully requests paper compliance on the attached plan of correction. ="" p=""> ="" p=""> ="" span="">	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to maintain resident's dignity while assisting residents with the meal for 2 of 2 dining observations. Staff stood while assisting the resident. (Resident 27) Findings include: During a dining room observation on 4/7/25 at 12:23 p.m. until 12:40 p.m., CNA 1 was observed to stand to the left of Resident 27 to assist the	F 0550	/p> **F550** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Education was provided on	04/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Phil Ford	Executive Director	04/25/2025

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.

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	resident with the meal. CNA 1 then placed her hand on the forehead of Resident 27 to hold her head up while she placed a spoon in the resident's mouth. CNA 1 did not talk with Resident 27, she was observed to talk with other staff members while they assisted residents during the noon meal. During an observation on 4/8/25 at 12:20 p.m., Resident 27 was observed eating with assistance of the Activity Director (AD). The AD was observed to be standing in front of the resident while assisting with the meal. On 4/8/25 at 1:39 p.m., Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and psychosis (when people lose some contact with reality). The Quarterly Minimum Data Set (MDS) assessment, dated 3/15/25, indicated no BIMS (Brief Interview for Mental Status) score. An ADL (Activities of Daily Living) care plan (revised on 12/23/24), indicated the resident had an ADL self-care performance deficit related to dementia. The care plan indicated that the resident was dependent on staff for assistance with meals. During an interview on 4/9/25 at 1:55 p.m., CNA 3 indicated Resident 27 required total assistance with meals. CNA 3 indicated that while assisting residents with meals, staff should not stand while assisting with meals, and should engage residents not other staff. On 4/9/25 at 3:52 p.m., the DNS (Director of Nursing Services) provided a copy of Resident Rights (undated), she indicated this was a policy currently being used in the facility. A review of		4/15/25 by the DNS/designee to the facility Direct Care Staff pertaining to “Resident Rights and Dignity” as defined by the State Operations Manual with additional emphasis on promoting resident independence and dignity while dining. Facility Certified Nursing assistants were observed on 4/16/25, 4/17/25 and 4/18/25 by DNS and ADNS during mealtimes to ensure dignity during dining for the resident who requires staff assist with consuming meals. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents who are a feed assist have the potential to be affected. Residents who require staff assistance for meals were evaluated and were noted with no negative outcomes pertaining to the alleged deficient practice. An audit will be completed weekly x 6 weeks by the Director of Nursing Services and the Assistant Director of Nursing Services to identify any residents who are a feed assist and ensure that their care plans and orders are appropriate. All certified nursing assistants will be observed during mealtimes with a resident who	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	the Resident's Rights indicated "... Right of dignified existence: Be treated with consideration, respect and dignity, recognizing each resident's individuality,...A home-like environment..." 3.1-3(t)		requires feeding assistance and checked off on their competency and demonstration of feeding residents with dignity. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** A weekly audit of mealtimes x 6 weeks will be completed by the Director of Nursing and/or the Assistant Director of Nursing to identify any incidences requiring further education with staff. Any concerns found will be corrected immediately. The audits will be submitted to QAPI for review to decide if additional audits are warranted. "Resident Rights and Dignity" as defined by the State Operations Manual (with the additional emphasis on promoting resident independence and dignity while dining) will be covered during new care team member orientation before the care team member is allowed to assist with feeding residents. All new certified nursing assistants will be educated and observed during mealtimes and checked off on their competency and demonstration of feeding residents with dignity during their department specific orientation.	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
			How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place. On 4/23/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Assistant Director of Nursing Services/MDS coordinator, Dietary Manager, Social Services/Activity Director, and the Director of Rehab. To monitor compliance, there will be a weekly audit of mealtimes x 6 weeks to be completed by the Director of Nursing and/or the Assistant Director of Nursing to identify any incidences requiring further education with staff. Any concerns found will be corrected immediately. The audits will be submitted to QAPI for review to decide if additional audits are warranted. A 'Resident Rights and Dignity" in-service will be completed quarterly by all staff and random spot audits completed with certified nursing assistants during mealtimes. Any concerns will be addressed immediately. The facility alleges substantial compliance on: 4/29/2025	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on observation, interview, and record review, the facility failed to communicate the resident's choice of advance directive to the staff responsible for the resident's care for 1 of 1 residents reviewed for Advance Directive. (Resident 186) Findings include: On 4/7/25 at 2:28 p.m., Resident 186's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), left side hemiplegia (paralysis on one side), and schizophrenia. Resident 186's admission date was 3/31/25. The clinical record lacked documentation of the Indiana Physician Orders for Scope of Treatment (POST) form. During an interview on 4/8/25 at 10:55 a.m., the Director of Nursing (DNS) indicated Social Services would complete the POST form on admission, the nurse practitioner would review and sign, and then "scan" the POST form into the electronic health record (EHR) with a copy going in a binder at the nurse's station. The DNS could not locate the POST form in the EHR. With the DNS, the binder at the nursing station was observed to lack Resident 186's POST form. On 4/8/25 at 11:14 a.m., the DNS presented the POST form, dated 3/31/25. The POST form indicated Resident 186 requested Cardiopulmonary Resuscitation (CPR) and full medical attention. At that time, she indicated it	F 0578	**F578** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident 186's POST form was added on 4/16/25 by the DNS to the Emergency binder at the nurse's station and scanned into the resident chart on PointClickCare so that it is available to all staff. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Current facility residents have the potential to be affected. A 100% audit was completed on all residents to ensure that all resident Advanced Directives are available at the nurses' station in the emergency binders and scanned into PointClickCare. A policy review and post test was completed by all LPNs and RNs regarding the Advanced Directives policy which states "Upon admission, should the resident have an advanced	04/29/2025

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	was in the "scanned pile" which was not at the nursing station. On 4/9/25 at 3:53 p.m., the DNS provided the facility's policy, Residents' Rights Regarding Treatment and Advance Directives, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff..." 3.1-4(f)(5)		directive, copies will be made and placed on the chart as well as communicated to staff." **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** In the event that an advanced directive is not available prior to admission, one will be completed with the resident as part of the admission assessment process, immediately copied and placed in the emergency binder, and scanned into PointClickCare. An audit will be completed by DNS/designee during the weekly Clinical Meeting to ensure that the advanced directive is available in the binder and in PointClickCare. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place.** A 100% audit will be completed by **the DNS/designee**: weekly x 6 weeks to monitor compliance These audits will be submitted to QAPI for review to decide if additional audits are	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
			warranted. The facility alleges substantial compliance on: 4/29/2025	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints Based on observation, interview, and record review, the facility failed to protect the residents right to be free from physical restraints for 1 of 3 residents reviewed for restraints. Documentation of re-evaluation of the need for restraints was not completed. (Resident 27) Findings include: On 4/7/25 at 11:35 a.m., Resident 27 was observed sitting in a Broda chair awake in the hallway with leg straps over both legs to prevent her from getting out of the chair. On 4/7/25 at 2:40 p.m., Resident 27 was observed sitting in a Broda chair asleep in her room with leg straps over both legs to prevent her from getting out the chair. On 4/8/25 at 9:32 a.m., Resident 27 was observed sitting in a Broda chair asleep in her room with leg straps over both legs to prevent her from getting out of the chair On 4/8/25 at 10:00 a.m., Resident 27 observed sitting in a Broda chair in her room. Two patient care staff members released and repositioned the leg straps at that time. On 4/9/25 at 11:08 a.m., Resident 27 observed sitting in a Broda chair asleep in her room with leg straps over both legs to prevent her from getting	F 0604	**F604** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A new Informed Consent for Use of Restraints was completed for resident # 27 on 4/15/2025 including recommended time/duration/usage “In Broda chair while up out of bed and unsupervised until next quarterly review date. Re-evaluate use quarterly and PRN.” The release and reposition schedule reads “Release, toilet, and reposition every 2 hours and PRN while up in chair.” A new evaluation will be completed quarterly to re-assess the continued use of the Broda chair with straps. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**	04/29/2025

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	out of the chair. On 4/9/25 at 11:40 a.m., two patient care staff were observed in Resident 27's room with the resident, they released and repositioned leg straps. Resident 27's clinical record was reviewed on 4/8/25 at 1:39 p.m. The diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease (COPD), anxiety, and psychosis (when people lose some contact with reality). A physician order, dated 5/31/24, indicated "...Broda Chair with straps while up for safety and positioning, unable to maintain erect torso. Paces to the point of exhaustion and unaware of her environment. Release and reposition every 2 hours and as needed. Review quarterly and as needed for continued use of Broda Chair requirements..." The Quarterly Minimum Data Set (MDS) assessment, dated 3/15/25, lacked documentation for daily use of limb restraints. A Care Plan, revised 3/26/25, indicated, Broda chair with straps while up for safety and positioning. The Informed Consent for Use of Restraints, dated on 5/9/24 for Resident 27 indicated, ..."Broda Chair with leg straps to prevent resident from falling out of chair..." The document lacked recommended duration and release and reposition schedule. The Quarterly Adaptive Device Review, dated 1/31/25 for Resident 27 indicated, "...device initiated on 5/31/24,...Medical reason for use:		Any resident with a restraint has the potential to be affected. At present, resident #27 is the only resident with a true restraint. A weekly restraint audit will be conducted x 6 weeks to ensure all criteria are met for anyone with an active restraint. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The facility's restraint policy was updated on 4/15/2025 to include "A new consent form and evaluation will be completed quarterly to assess for continued use." The new policy was run through QAPI on 4/23/2025 for review and was approved. A UDA was added to the resident's chart to trigger quarterly once the initial review has been completed. The Director of Nursing Services or the Assistant Director of Nursing Services will complete the review quarterly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place.** The Director of Nursing Servies or Assistant Director of	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	unable to maintain erect torso...Rationale for continued use of restrictive device: positioning..." The clinical record lacked any previous quarterly reviews. During an interview with the DNS (Director of Nursing Services) on 4/9/25 at 3:20 p.m., the DNS indicated there were no further evaluations completed on Resident 27. She indicated evaluations should be completed quarterly for re-evaluation of continued need of restraint use. On 4/9/25 at 3:52 p.m., the DNS provided the facility's policy, "Restraint Free Environment" dated 7/15/24, and indicated it was a policy currently being used by the facility. A review of the policy indicated "...6...The resident's record needs to include documentation...ongoing re-evaluation of the need for the restraint..." 3.1-26(r) 3.1-26(s)		Nursing Services will complete the Restraint Care Audit Tool weekly x 6 weeks and then quarterly on all residents with an active restraint. These audits will be submitted to QAPI for review to decide if additional audits are warranted. The facility alleges substantial compliance on: 4/29/2025	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was given to the resident and resident's representative for 2 of 2 residents reviewed for hospitalization. (Resident 8, Resident 19). Findings include: 1. On 4/8/25 at 2:00 p.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and heart failure.	F 0623	**F623** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** There was no harm brought to the residents identified to have been affected by the deficient practice. Both residents' guardians were notified at time of transfer and bed hold policy was	04/29/2025

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	Resident 8's progress notes, dated 1/17/25 at 7:50 a.m., indicated Resident 8 was to go to the emergency room due to resident chest x-ray results indicated possible pneumonia. The SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer form, dated 1/17/25 at 7:30 a.m., indicated Resident 8 was transferred to the hospital. The progress notes and transfer form lacked documentation of a written notification of the transfer and discharge was given the resident or the resident's representative. 2. On 4/8/25 at 2:19 p.m., Resident 19's clinical record was reviewed. The diagnoses included, but were not limited to, epilepsy, diabetes mellitus, and gastro-esophageal reflux disease. Resident 19's progress notes, dated 2/3/25 at 3:49 p.m., indicated he was sent to the emergency room for a possible blood transfusion. The SNF/NF to Hospital Transfer form, dated 2/3/25 at 9:00 a.m., indicated Resident 19 was transferred to the hospital. Resident 19's progress notes, dated 2/11/25 at 1:49 a.m., indicated he was sent to the emergency room for bloody stools. The SNF/NF to hospital Transfer form, dated 2/11/25 at 2:40 a.m., indicated Resident 19 was transferred to the hospital. The progress notes and transfer form lacked documentation of a written notification of the transfer and discharge was given the resident or the resident's representative.		sent with the residents along with all other appropriate documents. State form 49669 was not sent with either resident at time of transfer. The policy has been reviewed and the transfer process sheet updated to include this document with all transfers in the future. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Any resident who transfers or discharges out of the facility has the potential to be affected. The transfer process sheet was updated at the nurses' station with the addition of the Notice of Transfer or Discharge to be sent with the resident along with the bed hold policy. All facility RNs and LPNs were educated through an in-service on the new transfer process sheet, the Notice of Transfer or Discharge, and associated documentation to be sent with resident upon transfer or discharge **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	During an interview on 4/9/25 at 12:05 p.m., the Director of Nursing Services (DNS) indicated they were unaware of needing to provide the resident or the resident's representative a written notification when the residents transfers or discharges. On 4/9/25 at 3:53 p.m., the DNS provided the facility policy, "Transfer and Discharge (including AMA [against medical advice]), revised date 3/20/25 and indicated this was the policy currently being used by the facility. A review of the policy indicated..."g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		The Notice of Transfer or Discharge form has been attached to the bed hold policy and placed in the transfer packets at the nurses station. The transfer process sheet was updated at the nurses' station with the addition of the Notice of Transfer or Discharge to be sent with the resident along with the bed hold policy. All facility RNs and LPNs were educated through an in-service on the new transfer process sheet, the Notice of Transfer or Discharge, and associated documentation to be sent with resident upon transfer or discharge. Additionally, all nurses have been educated on how to use the Transfer and Discharge Check Sheet located at the nurses' station **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place.** All transfers must be approved through the Director of Nursing Services. Each step of the transfer will be checked off on the Transfer and Discharge check sheet and then turned into the DNS to verify completion These check sheets will be submitted to QAPI for review to decide if additional audits are	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
			warranted. The facility alleges substantial compliance on: 4/29/2025	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set assessment for 4 of 12 residents reviewed. The admission from location, daily use of limb restraints, anticoagulant medications, and prognosis were coded incorrectly. (Resident 35, Resident 27, Resident 18, Resident 1). Findings include: 1. Resident 35's clinical record was reviewed on 4/8/25 at 11:24 a.m. The diagnosis included, but was not limited to, Alzheimer's Disease. Resident 35's admission date was 1/15/25. A review of nursing progress notes indicated Resident 35 had been staying with his sister in another state but had recently moved back to this area to be closer to where his brother lived. Resident 35's Admission Minimum Data Set (MDS) assessment, dated 1/28/25, indicated the resident had admitted from a nursing home. During an interview on 4/8/25 at 11:32 a.m., the Administrator indicated the resident had been living out of state with his sister prior to being admitted to the facility. During an interview on 4/8/25 at 1:58 p.m., the MDS Coordinator indicated the Admission MDS assessment for Resident 35 was incorrect because	F 0641	**F641** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The affected residents' MDS assessments were corrected on 4/16/2025 with the supervision of the Regional Clinical Reimbursement Specialist **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected. A 100% audit was completed on 4/14/2025 and 4/15/2025 of the most recent MDS assessments for every resident of the facility by the Regional Clinical Reimbursement Specialist. The areas audited were MDS sections A1805, J1400, N0415, and P. Any inaccuracies were immediately modified.	04/29/2025

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	the resident had admitted from home after living with his sister. A review of the RAI,Version 3.0 User's Manual, on 4/9/25 at 3:30 p.m., indicated "... A1805 Code 01: Home/Community: if the resident was admitted from a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly ..." 2. Resident 27's clinical record was reviewed on 4/8/25 at 1:39 p.m. The diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease (COPD), anxiety, and psychosis (when people lose some contact with reality). A physician order, dated 5/31/24, indicated "...Broda Chair with straps while up for safety and positioning, unable to maintain erect torso. Paces to the point of exhaustion and unaware of her environment. Release and reposition every 2 hours and as needed. Review quarterly and as needed for continued use of Broda Chair requirements..." The Quarterly MDS assessment, dated 3/15/25, lacked documentation for daily use of limb restraints. During an interview with the Assistant Director of Nursing Services (ADNS)/ MDS Coordinator on 4/9/25 at 2:00 p.m., she indicated that the resident used limb restraints daily while in the Broda chair and the MDS assessment should have been coded to reflect that.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The facility MDS Coordinator completed re-education and testing on areas A1805, J1400, N0415, and P with the Regional Clinical Reimbursement Specialist on 4/16/2025 The Reimbursement Specialist for Journey Headquarters is currently conducting a continuous 100% audit through June 2025 for a Myers and Stauffer process improvement plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place.** The Simple LTC scrubber within PointClickCare will check for any inaccuracies before MDS assessments are sent to CMS. The Regional Clinical Reimbursement Specialist will continue to monitor all MDS assessments and audit monthly and quarterly. These audits will be submitted to QAPI for review to decide if additional audits are warranted.	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	A review of the RAI,Version 3.0 User's Manual, on 4/9/25 at 3:00 p.m., indicated "...P0100: Physical Restraints...Review the resident's medical record...to determine if physical restraints were used during the 7-day look-back period..." 3. Resident 18's clinical record was reviewed on 4/8/25 at 12:02 p.m. The diagnoses included, but were not limited to, COPD, dementia and schizophrenia (affects a person's ability to think, feel, and behave clearly). A physicians order, dated 8/17/24, indicated Eliquis Oral Tablet 2.5 MG (a medication to prevent and treat blood clots), give 1 tablet by mouth two times a day. The order was discontinued on 2/19/25. The Quarterly MDS assessment, dated 3/8/25, indicated resident's medication included an anticoagulant (a medication that reduce the blood's ability to clot, preventing or slowing down the formation of blood clots). During an interview with the Assistant Director of Nursing Services (ADNS)/ MDS Coordinator on 4/9/25 at 2:00 p.m., she indicated that the resident was not taking an anticoagulant at the time of the Quarterly MDS assessment and it should have been coded no. A review of the RAI,Version 3.0 User's Manual, on 4/9/25 at 3:00 p.m., indicated "...Item N0415, High-Risk Drug Classes: Use...Review the resident's medical record for documentation that any of these medications were received by the resident...during the 7-day lookback period..."4. Resident 1's clinical record was reviewed on 4/6/25 at 10:34 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's		The facility alleges substantial compliance on: 4/29/2025.	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	disease, and dementia. A 12/27/24 quarterly MDS assessment, indicated the resident did not have a life expectancy of less than 6 months for section J1400: Prognosis. A 3/15/24 physician's order indicated the resident was admitted to hospice care on 3/15/24. During an interview on 4/9/25 at 2:35 p.m., the MDS coordinator indicated she normally coded the MDS assessments as 'no' because she was taught to do so. She further indicated the Resident Assessment Instrument (RAI) manual was accessible to her when she completed the MDS assessments. During an interview on 4/9/25 at 3:52 p.m., the DNS indicated the facility did not have a policy related to MDS coding and the facility followed the RAI manual for coding purposes. On 4/10/25 at 11:56 a.m., a review of the "Center for Medicare and Medicaid Long-Term Care Facility Resident Assessment Instrument," dated October 2024, indicated, "... J1400: Prognosis ... Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services ..." 3.1-31(d)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure the sanitation bucket in the kitchen was at the correct level required for 1 of 1 sanitation bucket reviewed	F 0812	**F812** **What corrective action will be accomplished for those**	04/29/2025

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	during the kitchen initial tour. This has the potential to affect 35 of 35 residents served from the kitchen. Findings include: During the initial kitchen tour on 4/7/25 at 10:15 a.m., the Assistant Dietary Manager tested the sanitizing solution in the sanitation bucket on the three compartment sink. She used the test strip and dipped the strip in the sanitizing solution. She read the test strip color to the color chart on the bottle which indicated it was 170. She was unsure what color on the test strip bottle, the test strip should of been. On 4/7/25 at 10:36 a.m., the Assistant Dietary Manager indicated the sanitizing solution was low. It should of been 272-700. On 4/9/25 at 4:15 p.m., the Regional Registered Dietician provided the facility's policy, "The Sanitizing Buckets," revised 3/31/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...1. Cleaning and sanitizing buckets will be prepared at the start of each shift and replaced as needed in order to maintain proper concentration of cleaning/sanitizing solution..." 3.1-21(i)(2) 3.1-21(i)(3)		**residents found to have been affected by the deficient practice:** The sanitation bucket PH was corrected immediately upon discovery. The sanitation bucket is emptied and changed every two hours, PH checked for proper range and corrected if necessary. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected. Education was provided by the Dietary Manager during an in-service on 4/15/2025 to all kitchen employees highlighting where the test strips are located, what they are used for, and how to use them. Staff was shown how to read the test strips and what the proper range should be for the sanitation bucket. Each employee then demonstrated back to the Dietary Manager how to perform the PH testing which is done every 2 hours. The sanitation bucket will be emptied and changed every two hours, PH checked for proper range and corrected if necessary. **What measures will be put into**	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
			place and what systemic changes will be made to ensure that the deficient practice does not recur. Education was provided by the Dietary Manager during an in-service on 4/15/2025 to all kitchen employees as to where the test strips are located, what they are used for, and how to use them. Staff was shown how to read the test strips and what the proper range should be for the sanitation bucket. Each employee then demonstrated back to the Dietary Manager how to perform the PH testing which is done every 2 hours. The procedure for checking and changing the sanitation bucket will be posted by the bucket for reference. The sanitation bucket will be changed every two hours and the PH will be checked and logged by the Dietary Manager or Dietary Supervisor. If the PH is not within range, it will be corrected at that time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place.** The sanitation bucket will be changed every two hours and the PH will be checked and logged by	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
			the Dietary Manager or Dietary Supervisor. If the PH is not within range, it will be corrected at that time. The Registered Dietician will conduct a weekly audit of the sanitation bucket and log x 6 weeks to ensure that it is within range and being documented appropriately. These audits will be submitted to QAPI for review to decide if additional audits are warranted. The facility alleges substantial compliance on: 4/29/2025	
F 9999 Bldg. 00	3.1-14 Personnel (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employee reference checks were conducted prior to the start date for 5 of 5 employees reviewed for references. (CNA 1, RN 1, QMA 1, Housekeeping/Laundry aide 1, CNA 2) Findings include:	F 9999	**F9999** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected by the deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No residents have the potential to be affected by the	04/29/2025

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
	On 4/9/25 at 11:00 a.m., the employee records were reviewed. The reviewed included, but was not limited to: - CNA 1 had a start date of 3/21/25. - RN 1 had a start date of 11/12/24. - QMA 1 had a start date of 1/14/25. - Housekeeping/Laundry aide 1 had a start date of 1/19/25. - CNA 2 had a start date of 1/28/25. The employee records lacked documentation of the facility conducting reference checks prior to the start date for CNA 1, RN 1, QMA 1, Housekeeping/Laundry aide 1, and CNA 2. During an interview on 4/9/25 at 12:04 p.m., the Payroll Benefits Coordinator indicated the facility had not conducted employee reference checks on new employees and had not realized they needed to. On 4/9/25 at 3:35 p.m., the Regional Human Resource Partner provided the facility's policy,"Background Checks, Licensure and Certification Requirements and Investigations" dated, 1/7/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Policy: Professional reference checks are to be conducted, with a minimum of two references unless stated otherwise by state/federal regulations ..."		deficient practice **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The facility's policy "Background Checks, Licensure, and Certification Requirements and Investigations" was reviewed by our Regional HR Business Partner and our facility's HR/payroll/benefits coordinator. The facility HR/payroll/benefits coordinator signed verifying understanding of the facility policy. The Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Dietary Manager, and the Maintenance and Housekeeping supervisor also reviewed the facility's policy "Background Checks, Licensure, and Certification Requirements and Investigations" and signed verifying understanding of the facility's policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what Quality Assurance program will be put in place.** A pre-employment checklist will be used to complete all requirements before an official offer	

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	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	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
			of employment is made. A monthly audit of all new-hire pre-employment checklists will be completed x 3 months by the Regional HR Business Partner. These audits will be submitted to QAPI for review to decide if additional audits are warranted. The facility alleges substantial compliance on: 4/29/2025	