		OVIDER/SUPPLIER/CLIA IFICATION NUMBER 683	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       00       COMPLETE         B. WING       04/09/202			ETED	
	ROVIDER OR SUPPLIER NTOWN WOODS OF JOU	JRNEY	STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	MENT OF DEFICIENCIE ST BE PRECEDED BY FULL DENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000							
Bldg. 00	This visit was for a Recert Licensure Survey.  Survey dates: April 7, 8, a  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 accordance with 410 IAC  Quality review completed	nd 9, 2025 State Findings cited in 16.2-3.1.	F 0000	0	This plan of correction is prepared executed because it is required by the provisions of the state and federal regulations are citations listed on this statement of deficiencies. This plan of correction shall operate as Morgantown Woods of Journe written credible allegation of compliance. Morgantown Wood Journey respectfully request paper compliance on the attact plan of correction.  =""" p=""> =""" p="""> =""" span=""> =""" span="">	ne and nt y's ods ts	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercis	-					
	Based on observation, intereview, the facility failed the dignity while assisting restrained to a substitute of 2 of 2 dining observations assisting the resident. (Restriction of the substitute of the substitut	to maintain resident's idents with the meal for . Staff stood while sident 27)  ervation on 4/7/25 at a., CNA 1 was observed to	F 0550		F550 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:  Education was provided of	1	04/29/2025

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

TITLE

(X6) DATE

Phil Ford Executive Director 04/25/2025

Any defiency statement 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 disclodays 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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Event ID:

AP4F11 Facility ID:

000399

If continuation sheet

04/30/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15E683 B. WING 04/09/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 140 W WASHINGTON ST MORGANTOWN WOODS OF JOURNEY MORGANTOWN, IN 46160 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident with the meal. CNA 1 then placed her 4/15/25 by the DNS/designee to hand on the forehead of Resident 27 to hold her the facility Direct Care Staff head up while she placed a spoon in the resident's pertaining to "Resident Rights and mouth. CNA 1 did not talk with Resident 27, she Dignity" as defined by the State was observed to talk with other staff members Operations Manual with additional while they assisted residents during the noon emphasis on promoting resident independence and dignity while dining. During an observation on 4/8/25 at 12:20 p.m., Facility Certified Nursing Resident 27 was observed eating with assistance assistants were observed on of the Activity Director (AD). The AD was 4/16/25, 4/17/25 and 4/18/25 by observed to be standing in front of the resident DNS and ADNS during mealtimes while assisting with the meal. to ensure dignity during dining for the resident who requires staff On 4/8/25 at 1:39 p.m., Resident 27's clinical record assist with consuming meals. was reviewed. The diagnoses included, but were not limited to, dementia and psychosis (when How other residents having the people lose some contact with reality). potential to be affected by the same deficient practice will be The Quarterly Minimum Data Set (MDS) identified and what corrective assessment, dated 3/15/25, indicated no BIMS action will be taken. (Brief Interview for Mental Status) score. All residents who are a feed An ADL (Activities of Daily Living) care plan assist have the potential to be (revised on 12/23/24), indicated the resident had affected. Residents who require an ADL self-care performance deficit related to staff assistance for meals were dementia. The care plan indicated that the resident evaluated and were noted with no was dependent on staff for assistance with meals. negative outcomes pertaining to the alleged deficient practice. During an interview on 4/9/25 at 1:55 p.m., CNA 3 An audit will be completed indicated Resident 27 required total assistance

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

with meals. CNA 3 indicated that while assisting

residents with meals, staff should not stand while

assisting with meals, and should engage residents

are appropriate. All certified nursing assistants will be observed during mealtimes with a resident who

weekly x 6 weeks by the Director

Services to identify any residents

who are a feed assist and ensure that their care plans and orders

of Nursing Services and the

Assistant Director of Nursing

AP4F11 Event ID: Facility ID: 000399 If continuation sheet Page 2 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete

not other staff.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E683	(X2) MULTIPLE C A. BUILDING B. WING	OOSTRUCTION OO	(X3) DATE SURVEY COMPLETED 04/09/2025
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST GANTOWN, IN 46160	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION DATE
	dignified existences	ts indicated " Right of Be treated with consideration, recognizing each resident's ome-like environment"		requires feeding assistance checked off on their compet and demonstration of feedin residents with dignity.	ency
	3.1-3(t)			What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur.	into
				A weekly audit of meal x 6 weeks will be completed the Director of Nursing and/Assistant Director of Nursing identify any incidences requ	by or the g to
				further education with staff. concerns found will be corre immediately. The audits will submitted to QAPI for review decide if additional audits ar warranted.	ected be v to
				"Resident Rights and Dignity" as defined by the S Operations Manual (with the additional emphasis on pror resident independence and while dining) will be covered	e noting dignity
				new care team member orie before the care team memb allowed to assist with feedin residents.  All new certified nursin	entation er is g
				assistants will be educated a observed during mealtimes checked off on their compet and demonstration of feedin residents with dignity during department specific orientat	and and ency g their

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Event ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/09/2025				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD  140 W WASHINGTON ST  MORGANTOWN, IN 46160					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				How the corrective action(s) will be monitored to ensure deficient practice will not redice. 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 whice included the Administrator, Director of Nursing Services, Assistant Director of Nursing Services/MDS coordinator, Dimector, and the Director of Rehab.  To monitor compliance, the 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 incidences requiring further education with staff. Any concept of the provided in additional audits are warranted.  A 'Resident Rights and Dignity" in-service will be completed quarterly by all start and random spot audits completed nursing assistant during mealtimes. Any concer will be addressed immediately. The facility alleges substantial	the cur  defich  etary ivity  there  any cerns etto  ff bleted ts rns y.			

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compliance on: 4/29/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		15E683	B. W	ING		04/09/2	025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	ION T		DEFICIENCY)		DATE
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(Request/Refuse/DDir Based on observation review, the facility of resident's choice of responsible for the residents reviewed for (Resident 186)  Findings include:  On 4/7/25 at 2:28 p. record was reviewed were not limited to,		F 0:		F578  What corrective action will b accomplished for those residents found to have been affected by the deficient practice:  Resident 186's POST for was added on 4/16/25 by the to the Emergency binder at the nurse's station and scanned in the resident chart on PointClickCare so that it is	nn rm DNS e	04/29/2025
	Resident 186's admi	ission date was 3/31/25.			available to all staff.  How other residents having potential to be affected by the		
		Orders for Scope of Treatment			same deficient practice will be		
	(POST) form.				identified and what corrective		
	Director of Nursing Services would comadmission, the nurse and sign, and then "electronic health recin a binder at the nunot locate the POST DNS, the binder at to observed to lack Re On 4/8/25 at 11:14 a	y on 4/8/25 at 10:55 a.m., the (DNS) indicated Social applete the POST form on the practitioner would review scan" the POST form into the cord (EHR) with a copy going arse's station. The DNS could are form in the EHR. With the the nursing station was sident 186's POST form.			action will be taken.  Current facility residents have the potential to be affect A 100% audit was completed on all residents to ensure that all resident Advan Directives are available at the nurses' station in the emerger binders and scanned into PointClickCare.  A policy review and post was completed by all LPNs ar RNs regarding the Advanced	nced ncy	
	indicated Resident 1				Directives policy which states		
		esuscitation (CPR) and full			"Upon admission, should the		
medical attention. At that time, she indicated it				resident have an advanced			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15E683 B. WING 04/09/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 140 W WASHINGTON ST MORGANTOWN WOODS OF JOURNEY MORGANTOWN, IN 46160 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was in the "scanned pile" which was not at the directive, copies will be made and nursing station. placed on the chart as well as communicated to staff." 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 What measures will be put into by the facility. A review of the policy indicated, place and what systemic "...3. Upon admission, should the resident have an changes will be made to advance directive, copies will be made and placed ensure that the deficient on the chart as well as communicated to the practice does not recur. staff..." In the event that an advanced 3.1-4(f)(5)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

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM			TE SURVEY MPLETED	
		15E683	B. W	ING		04/09/	2025	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD  140 W WASHINGTON ST  MORGANTOWN, IN 46160					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					warranted.			
					The facility alleges substantial compliance on: 4/29/2025			
F 0604	483.10(e)(1), 483							
SS=D	Right to be Free f	rom Physical Restraints						
Bldg. 00	Dagad on absorpati	on interviews and record	F 0.	CO 4	F004		04/20/2025	
		on, interview, and record failed to protect the residents	F 00	504	F604		04/29/2025	
	-	n physical restraints for 1 of 3			What corrective action will b	<u> </u>		
	_	for restraints. Documentation			accomplished for those			
	of re-evaluation of	the need for restraints was not			residents found to have been	n		
	completed. (Reside	ent 27)			affected by the deficient			
					practice:			
	Findings include:							
					A new Informed Consent			
		a.m., Resident 27 was observed			Use of Restraints was comple			
	-	hair awake in the hallway with			for resident # 27 on 4/15/2025	)		
	getting out of the cl	n legs to prevent her from			including recommended			
	getting out of the ci	nan.			time/duration/usage "In Broda chair while up out of bed and			
	On 4/7/25 at 2:40 m	o.m., Resident 27 was observed			unsupervised until next quarte	₁rl∨		
	-	hair asleep in her room with leg			review date. Re-evaluate use	y		
	~	gs to prevent her from getting			quarterly and PRN." The relea	ise		
	out the chair.				and reposition schedule reads			
					"Release, toilet, and reposition	1		
		.m., Resident 27 was observed			every 2 hours and PRN while	up in		
	_	hair asleep in her room with leg			chair."			
		gs to prevent her from getting			A new evaluation will be			
	out of the chair				completed quarterly to re-asse			
	On 4/8/25 at 10:00	a.m., Resident 27 observed			the continued use of the Broda	a		
		hair in her room. Two patient			chair with straps.			
	-	released and repositioned the			How other residents having t	the		
	leg straps at that tir				potential to be affected by th			
					same deficient practice will be			
	On 4/9/25 at 11:08	a.m., Resident 27 observed			identified and what correctiv			
	sitting in a Broda c	hair asleep in her room with leg			action will be taken.			
	straps over both leg	gs to prevent her from getting						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPI	LETED
		15E683	B. W	ING		04/09	/2025
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
MODOM	NTOWN WOODO O	NE JOURNEY			WASHINGTON ST		
MORGAI	NTOWN WOODS C	OF JOURNEY		MORG	ANTOWN, IN 46160		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
	out of the chair.				Any resident with a restra	aint	
					has the potential to be affecte	d. At	
	On 4/9/25 at 11:40	a.m., two patient care staff were			present, resident #27 is the or		
	observed in Resident 27's room with the resident, they released and repositioned leg straps.				resident with a true restraint.	•	
					A weekly restraint audit v	will	
					be conducted x 6 weeks to en		
	Resident 27's clinic	al record was reviewed on			all criteria are met for anyone	with	
	4/8/25 at 1:39 p.m.	The diagnoses included, but			an active restraint.		
	were not limited to,	dementia, chronic obstructive					
	pulmonary disease (COPD), anxiety, and psychosis (when people lose some contact with reality).				What measures will be put in	nto	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
	A physician order,	dated 5/31/24, indicated			practice does not recur.		
	"Broda Chair with	h straps while up for safety and					
	positioning, unable	to maintain erect torso. Paces			The facility's restraint pol	licy	
	to the point of exha	ustion and unaware of her			was updated on 4/15/2025 to		
	environment. Relea	ase and reposition every 2			include "A new consent form a	and	
	hours and as needed	d. Review quarterly and as			evaluation will be completed		
	needed for continue	ed use of Broda Chair			quarterly to assess for continu	ıed	
	requirements"				use." The new policy was run		
					through QAPI on 4/23/2025 fo	or	
	The Quarterly Mini	mum Data Set (MDS)			review and was approved.		
	assessment, dated 3	1/15/25, lacked documentation			A UDA was added to the		
	for daily use of limb	b restraints.			resident's chart to trigger quai	rterly	
					once the initial review has bee	en	
	A Care Plan, revise	d 3/26/25, indicated, Broda			completed.		
	_	hile up for safety and			The Director of Nursing		
	positioning.				Services or the Assistant Dire		
					of Nursing Services will comp	lete	
		sent for Use of Restraints,			the review quarterly.		
		Resident 27 indicated,					
		h leg straps to prevent resident			How the corrective action(s)		
		chair" The document lacked			will be monitored to ensure	the	
	recommended dura	tion and release and reposition			deficient practice will not red	cur	
	schedule.				i.e. what Quality Assurance		
					program will be put in place.		
	The Quarterly Adap	ptive Device Review, dated					

1/31/25 for Resident 27 indicated, "...device

initiated on 5/31/24,...Medical reason for use:

AP4F11

The Director of Nursing

Servies or Assistant Director of

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00  B. WING			ETED (2005	
		15E683	B. W	ING		04/09/	2025	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
MORGAN	NTOWN WOODS O	E IOLIDNEV	140 W WASHINGTON ST MORGANTOWN, IN 46160					
	NIOWN WOODS O			WORG	ANTOWN, IN 40100			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
mo		erect torsoRationale for		mo	Nursing Services will complete the		DATE	
		strictive device: positioning"			Restraint Care Audit Tool wee			
	The clinical record	lacked any previous quarterly			6 weeks and then quarterly on	•		
	reviews.				residents with an active restra	int.		
					These audits will be			
	_	with the DNS (Director of			submitted to QAPI for review t	0		
		n 4/9/25 at 3:20 p.m., the DNS e no further evaluations			decide if additional audits are warranted.			
		ent 27. She indicated			warranteu.			
	_	be completed quarterly for			The facility alleges substantial			
	re-evaluation of con	ntinued need of restraint use.			compliance on: 4/29/2025			
		m., the DNS provided the						
		estraint Free Environment" ndicated it was a policy						
		d by the facility. A review of						
		"6The resident's record						
		cumentationongoing						
	re-evaluation of the	need for the restraint"						
	3.1-26(r)							
	3.1-26(s)							
F 0623	483.15(c)(3)-(6)(8)	)						
SS=D	Notice Requireme							
Bldg. 00	Transfer/Discharg							
	Based on interview	and record review, the facility	F 06	523	F623		04/29/2025	
		written notification required						
		scharge was given to the			What corrective action will b	е		
		t's representative for 2 of 2 for hospitalization. (Resident 8,			accomplished for those residents found to have been	_		
	Resident 19).	tor hospitalization. (Resident 8,			affected by the deficient	1		
					practice:			
	Findings include:				·			
					There was no harm broug	_		
		p.m., Resident 8's clinical			to the residents identified to ha			
		d. The diagnoses included, but			been affected by the deficient			
		chronic obstructive pulmonary on, and heart failure.			practice. Both residents' guardians were notified at time	e of		
	disease, hypertensio	m, and neart failure.			transfer and bed hold policy w			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED	
		15E683	B. Wl	ING		04/09/2025	
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		$\dashv$
NAME OF I	PROVIDER OR SUPPLIER	₹			WASHINGTON ST		
MODOAI	NTOWN WOODS C	NE IOLIBNIEV					
MURGAI	ALOMN MOODS C	OF JOURNEY		MORGA	ANTOWN, IN 46160		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Resident 8's progres	ss notes, dated 1/17/25 at 7:50			sent with the residents along v	vith	
	a.m., indicated Resi	ident 8 was to go to the			all other appropriate documen	ts.	
	emergency room du	ue to resident chest x-ray			State form 49669 was not sen	t	
	results indicated po	ssible pneumonia.			with either resident at time of		
					transfer. The policy has been		
	The SNF/NF (skille	ed nursing facility/nursing			reviewed and the transfer proc	ess	
	facility) to Hospital	Transfer form, dated 1/17/25 at			sheet updated to include this		
	7:30 a.m., indicated	Resident 8 was transferred to			document with all transfers in	the	
	the hospital.				future.		
	The progress notes and transfer form lacked				How other residents having t	he	
	documentation of a	written notification of the			potential to be affected by th	e	
	transfer and dischar	rge was given the resident or			same deficient practice will b	e	
	the resident's repres	sentative.			identified and what corrective	e	
					action will be taken.		
	2. On 4/8/25 at 2:19	9 p.m., Resident 19's clinical					
	record was reviewe	d. The diagnoses included, but			Any resident who transfe	rs	
	were not limited to,	epilepsy, diabetes mellitus,			or discharges out of the facility	,	
	and gastro-esophag	eal reflux disease.			has the potential to be affected	d.	
					The transfer process she	et	
		ess notes, dated 2/3/25 at 3:49			was updated at the nurses' sta	ntion	
	1 ~	vas sent to the emergency room			with the addition of the Notice	of	
	for a possible blood	l transfusion.			Transfer or Discharge to be se	ent	
					with the resident along with the	Э	
		spital Transfer form, dated			bed hold policy.		
		indicated Resident 19 was			All facility RNs and LPNs		
	transferred to the ho	ospital.			were educated through an		
					in-service on the new transfer		
		ess notes, dated 2/11/25 at 1:49			process sheet, the Notice of		
		vas sent to the emergency room			Transfer or Discharge, and		
	for bloody stools.				associated documentation to b		
					sent with resident upon transfe	er or	
		spital Transfer form, dated			discharge		
		., indicated Resident 19 was				_	
	transferred to the hospital.				What measures will be put in place and what systemic	to	
	The progress notes	and transfer form lacked			changes will be made to		
	documentation of a written notification of the			ensure that the deficient			
		rge was given the resident or			practice does not recur.		
	the resident's repres				F		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

AP4F11 Facility ID: 000399

If continuation sheet Page 10 of 20

04/30/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/09/2025 15E683 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 140 W WASHINGTON ST MORGANTOWN WOODS OF JOURNEY MORGANTOWN, IN 46160 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The Notice of Transfer or During an interview on 4/9/25 at 12:05 p.m., the Discharge form has been attached Director of Nursing Services (DNS) indicated they to the bed hold policy and placed were unaware of needing to provide the resident in the transfer packets at the or the resident's representative a written nurses station. notification when the residents transfers or The transfer process sheet was updated at the nurses' station discharges. with the addition of the Notice of On 4/9/25 at 3:53 p.m., the DNS provided the Transfer or Discharge to be sent facility policy, "Transfer and Discharge (including with the resident along with the AMA [against medical advice]), revised date bed hold policy. 3/20/25 and indicated this was the policy currently All facility RNs and LPNs being used by the facility. A review of the policy were educated through an indicated..."g. Provide a notice of transfer and the in-service on the new transfer facility's bed hold policy to the resident and process sheet, the Notice of representative as indicated..." Transfer or Discharge, and associated documentation to be 3.1-12(a)(6)(A)(i)sent with resident upon transfer or 3.1-12(a)(6)(A)(iii) 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

FORM CMS-2567(02-99) Previous Versions Obsolete

AP4F11

Event ID:

Facility ID: 000399

If continuation sheet

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

Page 11 of 20

NAME OF PROVIDER OR SUPPLIER  MORGANTOWN WOODS OF JOURNEY  AND SUMMARY STATEMENT OF DEFICIENCIE  TAG  SUMMARY STATEMENT OF DEFICIENCY  Warranted.  FO641  F641  F641	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED	
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  FOR 41 SS=E Bldg. 00  Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MB/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.  During an interview on 4/8/25 at 11:32 a.m., the Administrator indicated the resident had admitted from a nursing home.  During an interview on 4/8/25 at 11:35 p.m., the  During an interview on 4/8/25 at 11:58 p.m., the  During an interview on 4/8/25 st. 158 p.m., the  During an interview on 4/8/25 at 11:58 p.m., the  During an interview on 4/8/25 at 1:58 p.m., the  During an interview on 4/8/25 at 1:58 p.m., the  During an interview on 4/8/25 at 1:58 p.m., the  During an interview on 4/8/25 at 1:58 p.m., the  During an interview on 4/8/25 at 1:58 p.m., the					140 W WASHINGTON ST			
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(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  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.		Resident 35's Admi	ssion Minimum Data Set			All residents have the		
resident had admitted from a nursing home.  A 100% audit was completed on 4/14/2025 and 4/15/2025 of the most recent MDS assessments Administrator indicated the resident had been living out of state with his sister prior to being admitted to the facility.  Buring an interview on 4/8/25 at 1:58 p.m., the  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.								
on 4/14/2025 and 4/15/2025 of the 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  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.						1 -	eted	
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  for every resident of the facility by the Regional Clinical Reimbursement Specialist. The areas audited were MDS sections A1805, J1400, N0415, and P.			-			·		
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  the Regional Clinical Reimbursement Specialist. The areas audited were MDS sections A1805, J1400, N0415, and P.		During an interview	on 4/8/25 at 11:32 a.m., the			most recent MDS assessment	ts	
admitted to the facility.  Reimbursement Specialist. The areas audited were MDS sections During an interview on 4/8/25 at 1:58 p.m., the  A1805, J1400, N0415, and P.							y by	
During an interview on 4/8/25 at 1:58 p.m., the areas audited were MDS sections A1805, J1400, N0415, and P.						_		
During an interview on 4/8/25 at 1:58 p.m., the A1805, J1400, N0415, and P.		admitted to the facil	lity.			I -		
		D :						
LIVERA A AOGUNIZO E MORCAGO DE AORINSTOLIVERA LE LA DIVENDE MATA LE LA DIVENDE MATA		_	-					
assessment for Resident 35 was incorrect because immediately modified.						1		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15E683	B. W	ING _		04/09/	2025
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			WASHINGTON ST		
MORGAI	NTOWN WOODS C	OF JOURNEY			ANTOWN, IN 46160		
	ı				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		mitted from home after living			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	.4	
	with his sister.				What measures will be put in	ito	
	A marriage af the DA	I Vancion 2 O Hamla Manual			place and what systemic		
		I,Version 3.0 User's Manual, m., indicated " A1805 Code			changes will be made to		
		nity: if the resident was admitted			ensure that the deficient		
		e, apartment, board and care,			practice does not recur.		
		ity, group home, transitional			The facility MDS Coordin	ator	
		er care. A community			completed re-education and	atul	
	_	s defined as any house,			testing on areas A1805, J140	า	
	_	partment in the community,			N0415, and P with the Region	•	
	-	the resident or another person;			Clinical Reimbursement Spec		
	-	nities; or independent housing			on 4/16/2025	ianot	
		. Resident 27's clinical record			The Reimbursement		
	-	8/25 at 1:39 p.m. The diagnoses			Specialist for Journey		
		not limited to, dementia,			Headquarters is currently		
	· ·	pulmonary disease (COPD),			conducting a continuous 100%	6	
		osis (when people lose some			audit through June 2025 for a		
	contact with reality	).			Myers and Stauffer process		
					improvement plan.		
	A physician order,	dated 5/31/24, indicated					
	"Broda Chair witl	h straps while up for safety and			How the corrective action(s)		
	positioning, unable	to maintain erect torso. Paces			will be monitored to ensure t	the	
	to the point of exha	ustion and unaware of her			deficient practice will not red	cur	
		ase and reposition every 2			i.e. what Quality Assurance		
		d. Review quarterly and as			program will be put in place.		
		ed use of Broda Chair					
	requirements"				The Simple LTC scrubbe		
					within PointClickCare will chee		
		S assessment, dated 3/15/25,			for any inaccuracies before M		
		on for daily use of limb			assessments are sent to CMS	S.	
	restraints.				The Regional Clinical		
	<u></u>	14.4.4.14.451			Reimbursement Specialist will		
	_	w with the Assistant Director of			continue to monitor all MDS		
		ADNS)/ MDS Coordinator on			assessments and audit month	ıly	
	_	she indicated that the resident			and quarterly.		
		daily while in the Broda chair	These audits will be				
		sment should have been			submitted to QAPI for review t	io	
	coded to reflect that	t.			decide if additional audits are		
	I		1		warranted.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G	00	COMPLETED	
		15E683	B. WING		_	04/09/	2025
NAME OF P	DROWNER OF GURPLIES		STRI	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		140	W۷	WASHINGTON ST		
	NTOWN WOODS C	F JOURNEY	МО	RG/	ANTOWN, IN 46160		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION  I,Version 3.0 User's Manual,	TAG		DEFICIENCE		DATE
		m., indicated "P0100: Physical			The facility alleges substantial	l	
	_	the resident's medical			compliance on: 4/29/2025.	l	
		e if physical restraints were					
	used during the 7-da	ay look-back period"					
	3. Resident 18's clir	nical record was reviewed on					
		. The diagnoses included, but					
	were not limited to,	COPD, dementia and					
		cts a person's ability to think,					
	feel, and behave cle	early).					
	A physicians order,	dated 8/17/24, indicated					
		2.5 MG (a medication to					
	1 -	ood clots), give 1 tablet by					
	mouth two times a	day. The order was					
	discontinued on 2/1	9/25.					
	The Quarterly MDS	S assessment, dated 3/8/25,					
	indicated resident's	medication included an					
	anticoagulant (a me	dication that reduce the					
		ot, preventing or slowing down					
	the formation of blo	ood clots).					
	During an interview	with the Assistant Director of					
		ADNS)/ MDS Coordinator on					
		she indicated that the resident					
		nticoagulant at the time of the					
		essment and it should have					
	been coded no.						
	A review of the RA	I,Version 3.0 User's Manual,					
		m., indicated "Item N0415,					
	High-Risk Drug Cla	asses: UseReview the					
		ecord for documentation that					
	1 -	ations were received by the					
	1	e 7-day lookback period"4.					
		l record was reviewed on 4/6/25					
		iagnoses included, but were not					
	limited to, Alzheim	er's disease, Parkinson's	1				

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Event ID:

AP4F11

Facility ID: 000399

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E683	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 04/09/	LETED
	PROVIDER OR SUPPLIEF		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ANTOWN, IN 46160		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	: IATE	(X5) COMPLETION DATE
	the resident did not than 6 months for s  A 3/15/24 physician was admitted to hose the MDS assessment taught to do so. She Resident Assessment was accessible to he MDS assessments.  During an interview DNS indicated the related to MDS cood the RAI manual for On 4/10/25 at 11:50 for Medicare and M Facility Resident A October 2024, indicated 1, yes: if the physician documents.	y MDS assessment, indicated have a life expectancy of less ection J1400: Prognosis.  a's order indicated the resident spice care on 3/15/24.  a on 4/9/25 at 2:35 p.m., the endicated she normally coded at as a 'no' because she was a further indicated the ent Instrument (RAI) manual er when she completed the entity of a did not have a policy ing and the facility followed coding purposes.  a.m., a review of the "Center Iedicaid Long-Term Care essessment Instrument," dated eated, " J1400: Prognosis medical record includes tation: 1) that the resident is the resident is receiving				
F 0812 SS=F Bldg. 00	Based on observation review, the facility	e/Prepare/Serve-Sanitary on, interview, and record failed to ensure the sanitation n was at the correct level	F 0812	F812 What corrective action will	be	04/29/2025

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required for 1 of 1 sanitation bucket reviewed

Event ID:

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Facility ID: 000399

If continuation sheet

accomplished for those

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> C		COMPL	COMPLETED	
15E683		B. WING 04/09/202			2025		
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST		
MORGANTOWN WOODS OF JOURNEY							
MURGAI	ALOMN MOODS C	OF JOURNEY		MORG	ANTOWN, IN 46160		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	.,,_	DATE
	during the kitchen i	nitial tour. This has the			residents found to have been	n	
	potential to affect 3	5 of 35 residents served from			affected by the deficient		
	the kitchen.				practice:		
					•		
	Findings include:				The sanitation bucket PH	.	
					was corrected immediately up		
	During the initial ki	itchen tour on 4/7/25 at 10:15			discovery.		
		Dietary Manager tested the			The sanitation bucket is		
	1	in the sanitation bucket on the			emptied and changed every to	NO.	
		sink. She used the test strip			hours, PH checked for proper		
		in the sanitizing solution. She			range and corrected if necess		
		olor to the color chart on the			Tange and corrected in necess	ary.	
	_	ted it was 170. She was unsure			How other residents having	tho	
		est strip bottle, the test strip			potential to be affected by th		
	should of been.	est strip bottle, the test strip			same deficient practice will I		
	should of occil.				identified and what corrective		
	On 4/7/25 at 10:36	a.m., the Assistant Dietary			action will be taken.	F	
		the sanitizing solution was			action will be taken.		
	low. It should of be	_			All regidents have the		
	low. It should of be	en 2/2-700.			All residents have the		
	On 4/0/25 at 4:15 n	.m., the Regional Registered			potential to be affected.	h	
		the facility's policy, "The			Education was provided	-	
	_	" revised 3/31/25, and indicated			the Dietary Manager during a	'	
	_	rrently being used by the			in-service on 4/15/2025 to all	a	
		f the policy indicated, "1.			kitchen employees highlighting	-	
		zing buckets will be prepared			where the test strips are locat		
	_	shift and replaced as needed in			what they are used for, and he		
		roper concentration of			use them. Staff was shown ho		
		-			read the test strips and what t		
	cleaning/sanitizing	Solution			proper range should be for the		
	2 1 21(;)(2)				sanitation bucket. Each emplo	-	
	3.1-21(i)(2)				then demonstrated back to the		
	3.1-21(i)(3)				Dietary Manager how to perfo		
					the PH testing which is done	every	
					2 hours.		
					The sanitation bucket wil		
					emptied and changed every to		
					hours, PH checked for proper		
					range and corrected if necess	ary.	
					What measures will be put in	nto	

DEPARTMENT OF HEALTH AND HUMAN SERVIC	CES
CENTERS FOR MEDICARE & MEDICAID SERVIC	ES

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E683	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER  MORGANTOWN WOODS OF JOURNEY		STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				place and what systemic changes will be made to ensure that the deficient practice does not recur.	
				Education was provided the Dietary Manager during at in-service on 4/15/2025 to all kitchen employees as to wher the test strips are located, who they are used for, and how to them. Staff was shown how to read the test strips and what the proper range should be for the sanitation bucket. Each employees then demonstrated back to the Dietary Manager how to perform the PH testing which is done of the PH testing wh	re at use o he e e e e e e e e e e e e e e e e e

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/09/2025			
NAME OF PROVIDER OR SUPPLIER  MORGANTOWN WOODS OF JOURNEY			STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
F 9999 Bldg. 00				the Dietary Manager or Dietary Supervisor. If the PH is not wit range, it will be corrected at th time.  The Registered Dietician conduct a weekly audit of the sanitation bucket and log x 6 weeks to ensure that it is withir 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	hin at will n		
Bidg. 00	written and implem prospective employ made for prospectiv have a personnel pound and any convictions 16-28-13-3.  This State rule was Based on interview failed to ensure employees reviewed	all have specific procedures ented for the screening of ees. Specific inquiries shall be we employees. The facility shall blicy that considers references in accordance with IC not met as evidenced by:  and record review, the facility ployee reference checks were the start date for 5 of 5 d for references. (CNA 1, RN 1, ping/Laundry aide 1, CNA 2)	F 9999	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 to potential to be affected by the same deficient practice will be identified and what corrective action will be taken.	he ed he e	04/29/2025	

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Findings include:

Event ID:

AP4F11

 ${\it Facility ID:} \quad 000399$ 

No residents have the

potential to be affected by the

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· '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E683	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/09/2025	
NAME OF PROVIDER OR SUPPLIER  MORGANTOWN WOODS OF JOURNEY			STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	On 4/9/25 at 11:00 reviewed. The reviewed. The reviewed. The reviewed. The reviewed. The reviewed imited to:  - CNA 1 had a start d. QMA 1 had a start. Housekeeping/Lau 1/19/25.  - CNA 2 had a start. The employee reconstruction the facility conduction the start date for CN Housekeeping/Laur. During an interviewer Payroll Benefits Company has been been been been been been been bee	a.m., the employee records were ewed included, but was not date of 3/21/25. ate of 11/12/24. t date of 1/14/25. undry aide 1 had a start date of		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.  The facility's policy "Background Checks, Licensu and Certification Requirement: and Investigations" was review by our Regional HR Business Partner and our facility's HR/payroll/benefits coordinator signed verifying understanding of the facility porton 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 polid "Background Checks, Licensu and Certification Requirement: 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 receive what Quality Assurance program will be put in place.  A pre-employment check	re, seved  or. solicy.  odd  decy re, sed  decey re, sed  decy re, sed  decy re, sed	
				will be used to complete all	Loffor	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/30/2025
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15E683 B. WING 04/09/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 140 W WASHINGTON ST MORGANTOWN WOODS OF JOURNEY MORGANTOWN, IN 46160 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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

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