	R MEDICARE & MEDIC				B NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		15E683	B. WING		04/29/2025		
	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 DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 04/29 Facility Number: 0 Provider Number: 100/2 At this Emergency I Morgantown Wood substantial complian Preparedness Requi Medicaid Participat CFR 483.73.	0/25 00399 15E683 289100 Preparedness survey, s of Journey was found in nce with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of	E 0000	/p> /p> /p> /p> /p> /p> /p>			
E 0039 SS=C Bldg	Quality Review completed on 05/02/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: 403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements		E 0039	/p> /p> /p> /p> /p> /p> /p> /p> /p> E039		05/29/2025	

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

TITLE (X6) DATE

Phil Ford Executive Director 05/16/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: AP4F21 Facility ID: 000399 If continuation sheet Page 1 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		A. BUILDING CO		(X3) DATE SURVEY COMPLETED 04/29/2025			
	PROVIDER OR SUPPLIER		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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	facility-based function or man-made emerge of the emergency plant from engaging its not community-based of full-scale functional the onset of the actual (ii) Conduct an additional exercise. It is a community-based of functional exercises. It is a community-based of functional exercises, or preparable in the community of functional exercises, or preparable in the community of facility is emergent to the community of facility's emergent exercises, and emergent exercises, and emergent exercises, and emergent exercises.	y experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based lexercise for 1 year following hale event. It itional exercise that may simited to the following: alle exercise that is or an individual, facility-based drill; or see or workshop that is led by a des a group discussion, using y relevant emergency scenario, in statements, directed red questions designed to		What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified, but all facility reside would benefit from both a community-based emergency exercise and a facility-based emergency exercise. Both we scheduled but not yet completed by Mar 29, 2025. How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken. No specific residents were identified, but all facility reside would benefit from both a community-based emergency exercise and a facility-based emergency exercise. Both we scheduled but not yet completed by Mar 29, 2025.	ents / ere eted. ay the he be ve ents / ere eted.		
	with the Maintenand not provide docume full-scale exercise to annual individual, for exercise, a second for community-based of functional exercise, tabletop exercise or	riew on 04/29/25 at 11:10 a.m. ce Director, the facility could entation of; an annual hat is community-based, an facility-based functional full-scale exercise that is or an individual, facility-based a mock disaster drill, or a workshop that is led by a des a group discussion, using		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. A community-based emerger exercise and a facility-based exercise have been added to TELs Master Schedule which identify and continuously rem	ncy the will		

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

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E683	(X2) MULTIF A. BUILDII B. WING	NG <u></u>	(X3) DATE COMPI 04/29		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160				
MORGAI (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF a narrated, clinicall and a set of probler messages, or prepar challenge an emerg interview on 04/29/ Maintenance Direc unaware of the requ full-scale exercise t annual individual, t exercise, a second t community-based of functional exercise tabletop exercise of facilitator that inclu a narrated, clinicall and a set of probler messages, or prepar challenge an emerg he would discuss th Administrator and t possible.	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION The variable of the var	ID PREF	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	of their Director Master etion. the me /25 tance of nd their Master (s) re the recur ce ce. I v the which es, the the fasks as leted x e	(X5) COMPLETION DATE	

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

Event ID: AP4F21

Facility ID: 000399

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
		15E683	B. W	ING		04/29/	/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWIDEDIC DI AN 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	
K 0000								
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 04/29 Facility Number: 0 Provider Number: 1002 At this Life Safety 0 Woods of Journey w with Requirements 42 CFR Subpart 483 and the 2012 Edition Protection Association Code (LSC), Chapte Occupancies and 41 This one-story facility determined to be of fully sprinklered. The system with smoke all areas open to the battery-operated sm resident sleeping roc capacity of 39 and for of this visit. All areas where resi were sprinklered. The	200399 15E683 289100 Code survey, Morgantown was found not in compliance for Participation in Medicaid, 3.90(a), Life Safety from Fire n of the National Fire ion (NFPA) 101, Life Safety er 19, Existing Health Care 10 IAC 16.2. Type V (111) construction and the facility has a fire alarm detection in the corridors and a corridor. The facility has a looke detectors installed in all oms. The facility has a nad a census of 34 at the time idents have customary access the facility has one detached storage services which was	K 0	000	/p> /p> /p> /p> /p> /p>			

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 ${\tt Event \, ID:} \qquad {\sf AP4F21} \qquad {\tt Facility \, ID:} \quad {\sf 000399}$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> CC		COMPL	ETED
		15E683	B. WI	NG		04/29/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON ST		
MORGAN	NTOWN WOODS O	F JOURNEY			ANTOWN, IN 46160		
(X4) ID	SUMMARY S	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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0291	NFPA 101						
SS=F	Emergency Lightin	ng					
Bldg. 01							
	Based on record rev		K 0	291	K291		05/29/2025
		ility failed to ensure 16 of 16					
		s were tested monthly for 30			What corrective action will be	е	
		y for 90 minutes over the past			accomplished for those		
		ght would provide lighting			residents found to have beer	1	
		ower outages and a written			affected by the deficient		
	-	pections and tests was			practice:		
	provided. Section 7.9.3.1.1 (1) requires functional				No specific residents were		
	testing shall be conducted monthly, with a				identified, but all facility reside	nts	
	minimum of 3 weeks and a maximum of 5 weeks				could be affected.		
		ot less than 30 seconds, (3)					
		hall be conducted annually for			How other residents having t		
		hours if the emergency lighting			potential to be affected by th		
		wered and (5) Written records			same deficient practice will b		
	_	s and tests shall be kept by			identified and what corrective	е	
	_	etion by the authority having			action will be taken.		
	-	ficient practice could affect all			No specific residents were		
	residents, staff, and	visitors in the facility.			identified, but all facility reside		
					could be affected by not havin	_	
	Findings include:				properly operating emergency		
	D 1 1				lighting. The annual testing of		
		riew on 04/29/25 at 10:36 a.m.			emergency lighting was condu		
		ce Director, Battery- Operated			by the Maintenance Director o	n	
		ting documentation for the last			5/12/25 and found that all		
	_	d for the facilities sixteen			emergency lights were operati	ng	
	• •	ergency lights could not be			as they should.		
	_	an interview on 04/29/25 at			l		
	· ·	ntenance Director indicated the			What measures will be put in	το	
		operated emergency exit lights			place and what systemic		
	_	ity, but since this testing was			changes will be made to		
	•	gram, he was unaware of the			ensure that the deficient		
		s. Based on observations			practice does not recur.		
		of the facility with the			The Monthly and Annual testin	-	
		or on 04/29/25 from 11:31 a.m.			the Emergency Lighting have	been	
	_	ility had sixteen battery			added to the TELs Master	ام	
	operated exit lights	located at various locations.			Schedule which will identify ar	ıa	
			I		continuously remind the		

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PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> B. WING		COMPLETED	
		15E683	B. W			04/29/2025	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MODGAN	NTOWN WOODS C	NE IOLIBNIEV			WASHINGTON ST ANTOWN, IN 46160		
	ALOVAIA VAOODO C	OUNNET			TIN 1 O VVIN, IIN 40 100	r	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETI DATE	ION
IAU		ussed with the facility		IAU	Maintenance Director of their		
		he Maintenance Director at			dates. The Executive Director		
	the exit conference				also review the TELs Master		
					Schedule to ensure completio	٦.	
	3.1-19(b)				Education was provided to the	•	
					Maintenance Director by the		
					Executive Director on 5/12/25		
					concentrating on the importan these required functions and t		
					inclusion within the TELs Mas		
					Schedule.		
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not rec	ur	
					i.e. what Quality Assurance		
					program will be put in place.		
					On 5/15/2025, a QAPI		
					meeting was held to review the	e	
					Facility Plan of Correction whi		
					included the Administrator,		
					Director of Nursing Services,		
					Dietary Manager, Social		
					Services/Activity Director, the		
					Payroll/Benefits Clerk and the Maintenance Director.		
					A monthly audit of all		
					Required and Scheduled Task	s as	
					listed in TELs will be complete		
					3 months by the Executive		
					Director or the Maintenance		
					Director.		
					These audits will be	_	
					submitted to QAPI for review to decide if additional audits are	D	
					warranted.		
K 0300	NFPA 101						
SS=F	Protection - Other						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2025		
	ROVIDER OR SUPPLIER		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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 01	documentation for to of 20 of 20 battery or resident rooms was 4.6.12.3 states exist to the public, if not maintained. NFPA Tests. Fire-warning and tested in accord published instruction of Chapter 14. NFP testing, and mainter the requirements of equipment manufactor This deficient practic staff, and visitors. Findings include: Based on record rewwith the Maintenance itemized list of resides smoke alarms testin monthly basis during period available for on 04/29/25 at 9:47 acknowledged the bedetector manufacture monthly testing as finder. Based on obsetween 11:31 p.m. the facility with the operated smoke alar resident sleeping room.	cility failed to ensure he preventative maintenance operated smoke alarms in complete. NFPA 101 in ing life safety features obvious required by the Code, shall be 72, 29.10 Maintenance and equipment shall be maintained lance with the manufacturer's ins and per the requirements A 72, 14.2.1.1.1 Inspection, nance programs shall satisfy this Code and conform to the turer's published instructions. ice could affect all residents, where we was no dent room battery operated ag for functionality on a ag the past twelve-month review. Based on an interview a.m., the Maintenance Director outery-operated smoke are recommendations called for cound in his "Life Safety" observations made on 04/29/25 and 1:16 p.m. during a tour of Maintenance Director, battery tens were observed in all oms.	KO	300	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified, but all facility reside could be affected. 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 specific residents were identified, but all facility reside could be affected by not having properly operating battery operated smoke alarms. The monthly testing of the battery operated smoke alarms was conducted on 5/14/25 by the Maintenance Director and four that all battery operated smoke alarms were operating as they should. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Monthly testing of the batt operated smoke alarms has be added to the TELs Master Schedule which will identify an continuously remind the	nts the e e e e to	05/29/2025

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

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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 04/29/2025	
	PROVIDER OR SUPPLIEI		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ANTOWN, IN 46160	
	NTOWN WOODS O SUMMARY (EACH DEFICIEN				due r will n. e ace of cheir cter the cur
K 0324	NFPA 101			Director. These audits will be submitted to QAPI for review decide if additional audits are warranted.	to
SS=E	Cooking Facilities				

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Facility ID: 000399

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2025		
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST		
MORGAN	NTOWN WOODS O	F JOURNEY			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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01							
		on and interview, the facility	K 0	324	K324		05/29/2025
	-	approved method for			NAME - 4		
		ppliances to where they were bod extinguishing equipment			What corrective action will be accomplished for those	€	
		astalled for 1 of 1 kitchen hood			residents found to have beer		
	_	m. NFPA 96, Standard for			affected by the deficient		
		and Fire Protection of			practice:		
		ng Operations Section 2011			No specific residents were		
		1.2.2, states cooking appliances			identified, but all facility reside	nts	
	requiring protection shall not be moved, modified,				could be affected.		
	or rearranged without prior re-evaluation of the						
		ystem by the system installer			How other residents having t	he	
	or servicing agent, unless otherwise allowed by				potential to be affected by the		
	-	e extinguishing system.			same deficient practice will b		
		tes the fire-extinguishing			identified and what corrective	9	
		uire reevaluation where the			action will be taken.		
		are moved for the purposes of			No specific residents were		
		eaning, provided the ned to approved design			identified, but all facility reside		
		oking operations, and any			could be affected by not provid an approved method for return	-	
		ctinguishing system nozzles			the four burner stove to an	iiig	
		iances are reconnected in			approved design designated		
		manufacturer's listed design			location after it had been move	ed	
		1.2.3.1 states an approved			for maintenance and/or cleani		
	method shall be pro	vided that will ensure that the					
	appliance is returne	d to an approved design			What measures will be put in	to	
		ient practice could affect as			place and what systemic		
	many as 4 staff, in t	he facility.			changes will be made to		
					ensure that the deficient		
	Findings include:				practice does not recur.		
	Događ on abasar-4:	one mode during a tour of the			Wheel location will be designa		
		ons made during a tour of the intenance Director on 04/29/25			on the kitchen floor using dura tape applied on 5/13/25 by the		
	•	ur (4) burner stove and the flat			Maintenance Director at the		
	-	ated on the cooking line under			approved design location bene	eath	
	•	nen was not provided with an			the kitchen hood extinguishing		
		at would ensure that the			equipment to ensure proper		
		ned to an approved design			placement of the four burner		
		been moved for maintenance			stove. The Dietary Manager w	/ill	
			1		İ		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 9 01	x3) date survey COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIEF		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ANTOWN, IN 46160	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	1:04 p.m., the Main was not aware an approvided to ensure returned to an appromaintenance or cleasomething done to meet code complian. This item was discussed.	sed on interview on 04/29/25 at tenance Director stated that he oproved method should be that the appliance was oved design location after uning and that he would have the kitchen stove or floor to nee as soon as possible. Sessed with the Maintenance cility Administrator at the exit 09/25.		inspect the proper placement of the stove's wheels each mornin during morning rounds using the durable tape as the guide for the approved design location. How the corrective action(s) will be monitored to ensure the deficient practice will not recursive. What Quality Assurance program will be put in place. On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director. A monthly audit of proper placement of the four burner stousing the durable tape as the guide will be completed x 3 months by the Executive Director the Dietary Manager. These audits will be submitted to QAPI for review to decide if additional audits are warranted.	g e e e ir
K 0345 SS=F Bldg. 01	facility failed to ma	n - Testing and review and interview, the intain 1 of 1 fire alarm systems NFPA 72, National Fire Alarm v LSC Sections 19.3.4.5.1 and	K 0345	K345 What corrective action will be	05/29/2025

9.6. NFPA 72, Section 14.3.1 states that unless

accomplished for those

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ANTOWN, IN 46160	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
PREFIX TAG	otherwise permitted shall be performed schedules in Table by the authority has states that the follow inspected semi-annua. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op. This deficient pract occupants. Findings include: During record revied Director on 04/29/2 could not be provid semi-annual fire ala on interview on 04/Maintenance Direct semi-annual inspect had not been completed had called his vended documentation for the sent to him and it was of the time of this documented inspection. No othe provided. This item was discut.	by 14.3.2, visual inspections in accordance with the 14.3.1, or more often if required ring jurisdiction. Table 14.3.1 ving must be visually nally: ole signals tors (e.g. duct detectors, manual at detectors, smoke detectors, iances one devices ice could affect all building with the Maintenance 5 at 9:35 a.m., documentation ed regarding a visual rm system inspection. Based 29/25 at 9:37 a.m., the or agreed that a visual ion of the fire-alarm system eted based on the fact that he or and asked that all esting within the last year be as still not available for review is survey with the last ion of the fire alarm system 01/07/25 that was an annual redocumentation could be	PREFIX TAG	residents found to have bee affected by the deficient practice: No specific residents were identified, but all facility resid could be affected by the affected by the deficient practice. How other residents having potential to be affected by the same deficient practice will identified and what correcting action will be taken. No specific residents were identified, but all facility resid could be affected by not having properly operating fire alarm system. The semi-annual test of the fire alarm system was conducted on 1/7/25 and four that the fire alarm system was conducted on 1/7/25 and four that the fire alarm system was conducted on 1/7/25 completion and Test report showing the 1/7/25 completion date identified above, in the I section, point #11, is the date the most recent Smoke Detered Sensitivity Test which was 7/2 still in compliance (A copy of that inspection is also include with this packet) What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The semi annual testing of the alarm system and the two yes smoke detector sensitivity tests whose detector se	ents the he be ve ents ng a sting a sting a sting and s ded on ower e of ctor 14/23 of ed ed ents ar

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/29/2025		
		STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
facility failed to ensign was maintained in a LSC 9.6.1.3 require installed, tested, and with NFPA 70, Nati 72, National Fire Al 14.4.5 states unless sections of this Cod in accordance with or more often if required jurisdiction. NFPA smoke detector sensily a smoke detector sensily and the smoke detector sensily are after installated to the smoke detector sensily and the smoke detector sensily are after installated to the smoke detector sensitive to the smoke detector sensily are after installated to the smoke detector sensily are after installated to the smoke detector sensitive to the smoke detector sensi	sure 1 of 1 fire alarm systems accordance with LSC 9.6.1.3. Is a fire alarm system to be a maintained in accordance at a maintained in accordance and NFPA flarm Code. NFPA 72, Section otherwise permitted by other e, testing shall be performed the schedules in Table 14.4.5, uired by the authority having 72, Section 14.4.5.3.1 states attivity shall be checked within action. NFPA 72, 14.4.5.3.2 states attivity shall be checked every after unless otherwise itance with Section 14.4.5.3.3.		have been added to the TELs Master Schedule by the Maintenance Director on 5/13 which will identify and continuously remind the Maintenance Director of their dates. The Executive Director also review the TELs Master Schedule to ensure completic Education was provided to the Maintenance Director by the Executive Director on 5/12/25 concentrating on the importar these required functions and inclusion within the TELs Mass Schedule. How the corrective action(s) will be monitored to ensure deficient practice will not reie, what Quality Assurance program will be put in place	due or will on. e ince of their ster the cur		
Director on 04/29/2 could not be provide sensitivity testing we on interview on 04/2 Maintenance Direct detector sensitivity detectors had not be two year period bas called his vendor and documentation for the years be sent to him for review as of the This item was discurded.	5 at 10:18 a.m., documentation ed regarding a smoke detector within the last two years. Based 29/25 at 10:20 a.m., the or agreed that a smoke test of the facility smoke ten completed within the last ed on the fact that he had asked that all esting within the last two a and it was still not available time of this survey.		On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction who included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director. A monthly audit of all Required and Scheduled Tass listed in TELs will be completed 3 months by the Executive Director or the Maintenance Director. These audits will be	ks as ed x		
	SUMMARY SUPPLIER ROVIDER OR SUPPLIER SUMMARY SUMMARY SUMMARY SUMMARY SUPPLIER REGULATORY OR 2) Based on record facility failed to ensum a maintained in a LSC 9.6.1.3 require installed, tested, and with NFPA 70, Nati 72, National Fire Al 14.4.5 states unless sections of this Cod in accordance with sor more often if requires installed, tested, and with NFPA 70, Nati 72, National Fire Al 14.4.5 states unless sections of this Cod in accordance with sor more often if requires detector sensulternate year therea permitted by compl. This deficient practic within the facility. Findings include: Based on record revelocity by the provides sensitivity testing when the provides the	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants within the facility.	ROVIDER OR SUPPLIER ### ATOWN WOODS OF JOURNEY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3 LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 72, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants within the facility. Findings include: Based on record review with the Maintenance Director on 04/29/25 at 10:18 a.m., documentation could not be provided regarding a smoke detector sensitivity testing within the last two years. Based on interview on 04/29/25 at 10:20 a.m., the Maintenance Director agreed that a smoke detector sensitivity test of the facility smoke detector agreed that a smoke detector sensitivity as of the time of this survey. This item was discussed with the Maintenance Director and the facility Administrator at the exit	ROVIDER OR SUPPLIER ROWN WOODS OF JOURNEY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION 2) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, are more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.2. states smoke detector sensitivity stall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants within the facility. Based on record review with the Maintenance Director on 04/29/25 at 10-20 a.m., the Maintenance Director on 04/29/25 at 10-20 a.m., the Maintenance Director on on 04/29/25 at 10-20 a.m., the Maintenance Director on on 04/29/25 at 10-20 a.m., the Maintenance Director on on 04/29/25 at 10-20 a.m., the Maintenance Director on on 04/29/25 at 10-20 a.m., the Maintenance Director on 04/29/25 at 10-20 a.m., the Maintenanc		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIER		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST GANTOWN, IN 46160	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL U. S.C. IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	3.1-19(b)	LSC IDENTIFYING INFORMATION	TAG	decide if additional audits are warranted.	DATE
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System Based on record reversal failed to provide were vidence the sprink been inspected and 4.6.12.1 requires an required for complimation of the Inspection, Toward water-Based Fire Personal failed failed water-Based Fire Personal failed fai	riew and interview, the facility ritten documentation or other ler system components had tested for 2 of 4 quarters. LSC y device, equipment or system ance with this Code be dance with applicable NFPA akler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the risdiction upon request. 4.3.2 is shall indicate the procedure pection, test, or maintenance), at performed the work, the see NFPA 25, 5.2.5 requires that vices shall be inspected they are free of physical 5.3.3.1 requires the mechanical vices including, but not limited gs, shall be tested quarterly. e-type and pressure ow alarm devices shall be the tractice could staff, and visitors in the	K 0353	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified, but all facility reside could be affected. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No specific residents were identified, but all facility reside could be affected by not havin quarterly sprinkler system inspections. The first quarterly sprinkler system inspection was performed on 1/7/25 by Super Systems. The second quarter inspection of the sprinkler system will be conducted on 5/19/25 by Superior Systems.	nts the e pe e nts g y as ior rly tem
		view of the quarterly sprinkler ecords on 04/29/25 at 9:50 a.m.		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.	ito

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 04/29/2025 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 with the Maintenance Director, there were no The quarterly inspection of the quarterly sprinkler system inspection reports sprinkler system has been added available for the third quarter (July, August, and to the TELs Master Schedule September) or the fourth quarter (October, which will identify and November, and December) of 2024. Based on an continuously remind the interview on 04/29/25 at 9:54 a.m., the Maintenance Director of their due Maintenance Director acknowledged there was no dates. The Executive Director will written documentation available to show the also review the TELs Master sprinkler system had been inspected during the Schedule to ensure completion. third or fourth quarters of 2024 based on the fact Education was provided to the that he had called his vendor and asked that all Maintenance Director by the documentation for testing within the last year be Executive Director on 5/12/25 sent to him and it was still not available for review concentrating on the importance of as of the time of this survey. these required functions and their inclusion within the TELs Master This item was discussed with the Maintenance Schedule. Director and the facility Administrator at the exit conference on 04/29/25. How the corrective action(s) will be monitored to ensure the 3.1-19(b) deficient practice will not recur i.e. what Quality Assurance program will be put in place. On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction which included the Administrator. Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director. A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director. These audits will be submitted to QAPI for review to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2025		
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 ICY 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)	TE	(X5) COMPLETION DATE
					decide if additional audits are warranted.		
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills						
Bidg. 01	facility failed to en the verification of t signal to the monitulast 4 quarters. LSC health care occupant transmission of a fi of emergency fire of practice affects all as staff and visitors. Findings include: Based on record re "Direct Supply - The Maintenance D the documentation past twelve months transmission of the company for the dr 04/29/25 at 9:14 and stated that he was a verification of the the drills with the mon was not told of this training at this facility.	view of the document titled ELS (Conduct a fire drill) with irector on 04/29/25 at 9:12 a.m., for the fire drills for six of the lacked verification of the signal to the monitoring ills. Based on an interview on m., the Maintenance Director maware of the need for ransmission of the signal for itoring company stating that he requirement during his limited lity.	K 0	712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified, but all facility reside could be affected. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No specific residents were identified, but all facility reside could be affected by not havin properly scheduled fire drills the include verification of the transmission of the signal to the monitoring company for the driving and what systemic changes will be made to	nnts the e e nnts g nat ne iills.	05/29/2025
		assed with the Maintenance cility Administrator at the exit 9/25.			ensure that the deficient practice does not recur. Properly scheduled fire drills the include verification of the transmission of the signal to the monitoring company for the drivate been added to the TELs	ne ills	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPL	ETED
		15E683	B. W	B. WING 04/29/2			/2025
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			WASHINGTON ST		
MORGAI	NTOWN WOODS O	OF JOURNEY			ANTOWN, IN 46160		
WONGAI	TOWN WOODS	ZI GOOINILI		WONG/	- 111 - 10100		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	· ·	review and interview, the			Master Schedule which will		
		nduct quarterly fire drills for 2			identify and continuously remi		
	-	19.7.1.6 requires drills to be			the Maintenance Director of the		
		y on each shift under varied			due dates. The Executive Dir	ector	
		ficient practice affects all staff			will also review the TELs Mas		
	and residents.				Schedule to ensure completion		
					Education was provided to th	е	
	Findings include:				Maintenance Director by the		
					Executive Director on 5/12/25		
		view of the document titled			concentrating on the importan		
		ELS (Conduct a fire drill) with			these required functions and t		
		irector on 04/29/25 at 9:15 a.m.,			inclusion within the TELs Mas		
		nentation for a first quarter			Schedule. (Completed 3rd shi		
		, and March) of 2025 fire drill			Fire Drill for the 4th quarter or		
	-	the first or second shifts of			2024 was found in the Life Sa	-	
		there was no documentation			binder. Additionally, all three		
	_	g conducted in the fourth			the first quarter of 2025 Fire D		
		lovember, and December) of			were also found in a second f		
		hift. Based on an interview on			completed for all shifts. All 4	of	
		m., the Maintenance Director			these documents have been		
		aforementioned missing fire			uploaded.)		
		o further documentation could					
		drills as of the time of this			How the corrective action(s)		
	survey.				will be monitored to ensure		
					deficient practice will not red	cur	
		ussed with the Maintenance			i.e. what Quality Assurance		
		cility Administrator at the exit			program will be put in place.		
	conference on 04/2	9/25.					
					On 5/15/2025, a QAPI		
	3.1-19(b)				meeting was held to review th		
	3.1-51(c)				Facility Plan of Correction whi	ch	
					included the Administrator,		
					Director of Nursing Services,		
					Dietary Manager, Social		
					Services/Activity Director, the		
					Payroll/Benefits Clerk and the		
					Maintenance Director.		
					A monthly audit of all		
					Required and Scheduled Tasl		
					listed in TELs will be complete	ed x	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E683		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIE		140 W	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST GANTOWN, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				3 months by the Executive Director or the Maintenance Director. These audits will be submitted to QAPI for review to decide if additional audits are warranted.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipm Maintenanc	•			
	interview, the facil required maintenar documentation of i Related Electrical 2012 edition, section physical integrity, touch current tests is performed as require established with PCREE used in paraccordance with 10 into service and aff Any system consist appliances demons 99 as a complete syinstructions, and program for electrical equipment manuals are readily and condensed operappliance are legible equipment tests, remaintained for a percompliance in accorpolicy. Personnel r	view, observation, and ity failed to conduct the ace and maintain complete inspections for Patient Care Equipment (PCREE). NFPA 99 cons 10.3 and 10.5 states the resistance, leakage current, and for fixed and portable PCREE quired in 10.3. Testing intervals in policies and protocols. All tient care rooms is tested in 0.3.5.4 or 10.3.6 before being put ter any repair or modification. Iting of several electrical trates compliance with NFPA system. Service manuals, rocedures provided by the de information as required by considered in the development ectrical equipment maintenance. In instructions and maintenance of available, and safety labels rating instructions on the le. A record of electrical pairs, and modifications is eriod of time to demonstrate ordance with the facility's esponsible for the testing,	K 0921	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified, but all facility resider could be affected. 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 specific residents were identified, but all facility resider could be affected by not having properly scheduled a (PCREE) Patient Care Related Electrical Equipment inspection and documentation for those related devices put into service and affer any repair or modification of the related devices.	nts he e e d d ter ose
		se of electrical appliances		place and what systemic	

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u> Co		COMPL	COMPLETED	
	15E683		B. WING 04/29/2025			/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			WASHINGTON ST		
MORGAI	NTOWN WOODS (OF IOLIBNIEV			ANTOWN, IN 46160		
MONGA	- WIOWIN WOODS C	DI SOCIALI		WONG			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		training. This deficient			changes will be made to		
	practice could affect	et all residents.			ensure that the deficient		
					practice does not recur.		
	Findings include:				A properly scheduled (PCREE	•	
					Patient Care Related Electrica		
		view on 04/29/25 at 10:46 a.m.			Equipment inspection including	ıg	
		nce Director, there was no			the documentation for those		
		the testing of Patient Care			related devices put into service		
		Equipment (PCREE), such as			after any repair or modification	n of	
	·	lizers, oxygen concentrators, air			those related devices will be		
		resses, and other electrical			completed by 5/15/25 and has		
		Based on interview at 10:48			been added to the TELs Mast		
		nce Director stated that he was		Schedule by the Maintenance			
	_	ulations to conduct PCREE			Director on 5/13/25 which will		
	_	and a way to have it completed			identify and continuously remi		
	_	. Based on observations made			the Maintenance Director of the		
		and 1:16 p.m. during a tour of			due dates. The Executive Dir		
	-	e Maintenance Director, it was			will also review the TELs Mas		
		y provided PCREE such as			Schedule to ensure completion		
	_	imps for air mattresses, and		Education was provided to the			
		dical equipment was present in			Maintenance Director by the		
	the facility.				Executive Director on 5/12/25		
	This item was disa	ussed with the Maintenance			concentrating on the importan		
		cility Administrator at the exit			these required functions and to inclusion within the TELs Mas		
	conference on 04/2	_			Schedule.	lei	
	conference on 04/2	5125.			ochedule.		
	3.1-19(b)				How the corrective action(s)		
	3.1 17(0)				will be monitored to ensure		
				deficient practice will not recur			
					i.e. what Quality Assurance	,u:	
					program will be put in place.		
					program um se par m praesi		
					On 5/15/2025, a QAPI		
					meeting was held to review th	e	
					Facility Plan of Correction whi		
					included the Administrator,		
					Director of Nursing Services,		
					Dietary Manager, Social		
					Services/Activity Director, the		

						PRIN'	ΓED:	05/21/2025
DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0	938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	01	COMPLETED			
		15E683	B. WING			04/29/2025		
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	ΤF	COM	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		D	ATE
					Payroll/Benefits Clerk and the			
					Maintenance Director.			
					A monthly audit of all			
					Required and Scheduled Task	s as		

			Maintenance Director. A monthly audit of all Required and Scheduled Tasks as listed in TELs will be completed x 3 months by the Executive Director or the Maintenance Director. These audits will be submitted to QAPI for review to decide if additional audits are warranted.		
K 0923	NFPA 101				l
SS=E	Gas Equipment - Cylinder and Container				
Bldg. 01	Storag				ļ
	Based on observation and interview, the facility	K 0923	K923	05/29/2025	l
	failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000		What corrective action will be		l
	cubic feet were secured against unauthorized		accomplished for those		l
	entry. NFPA 99, Health Care Facilities Code, 2012		residents found to have been		l
	Edition, Section 11.3.2.1 states storage locations		affected by the deficient		l
	shall be outdoors in an enclosure or within an		practice:		l
	enclosed interior space of noncombustible or		No specific residents were		l
	limited combustible construction, with doors (or		identified, but all facility residents		l
	gates outdoors) that can be secured against		could be affected.		l
	unauthorized entry. This deficient practice could				l
	affect 25 staff and visitors in the vicinity of the		How other residents having the		l
	oxygen storage and transfilling room.		potential to be affected by the		l
	F: 1: 1 1		same deficient practice will be		l
	Findings include:		identified and what corrective action will be taken.		l
	Based on observations made with Maintenance		No specific residents were		l
	Director during a tour of the facility on 04/29/25 at		identified, but all facility residents		l
	11:45 a.m., the corridor entry door to the oxygen		could be affected by not having a		l
	storage and transfilling room was equipped with a		properly door that will fully latch		l
	lock or means to secure against unauthorized		into the door frame.		l
	entry, but the door did not fully close and latch				l

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into the doorframe when tested on three separate occasions. The room contained six liquid oxygen

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What measures will be put into

place and what systemic

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	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 04/29/2025				
	ROVIDER OR SUPPLIER		140 W	STREET ADDRESS, CITY, STATE, ZIP COD 140 W WASHINGTON ST MORGANTOWN, IN 46160					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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				
	REGULATORY OR containers and ten 'I interview on 04/29/2 Maintenance Direct of the regulation regoxygen transfilling need for the corrido into the doorframe a door serviced or rep	E' type cylinders. Based on 25 at 11:47 a.m., the or stated that he was unaware garding separation of the room by a 1-hour barrier or the r door to fully close and latch adding that he would have the paired as soon as possible.		changes will be made to ensure that the deficient practice does not recur. The door latch/frame was assessed by the Maintenance Director who determined the reformed a new door latch. The new door latch (knob-handle) was installed on 5/12/25. The door/latch was tested ten sep times by the Maintenance Director by the Maintenance Director and fully closed each of those times. How the corrective action(s) will be monitored to ensure deficient practice will not recise. what Quality Assurance program will be put in place. On 5/15/2025, a QAPI meeting was held to review the Facility Plan of Correction whi included the Administrator, Director of Nursing Services, Dietary Manager, Social Services/Activity Director, the Payroll/Benefits Clerk and the Maintenance Director. A monthly audit of proper placement of the functioning of this door latch will be completed a months by the Executive Director or the Maintenance Director. These audits will be submitted to QAPI for review decide if additional audits are	eneed v arate ector the cur r of ed x				
				warranted.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/21/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
		15E683	B. WING			04/29/2025	
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	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE

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