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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E683	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2024

NAME OF PROVIDER OR SUPPLIER **MORGANTOWN WOODS OF JOURNEY**	STREET ADDRESS, CITY, STATE, ZIP CODE **140 W WASHINGTON ST** **MORGANTOWN, IN 46160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00445786. Complaint IN00445786 - No deficiencies related to the allegations are cited. Survey date: November 26, 2024 Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census Bed Type: NF: 28 Total: 28 Census Payor Type: Medicaid: 23 Other: 5 Total: 28 Morgantown Woods of Journey was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00445786. Quality review completed November 27, 2024.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE