| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15E683 | A. BUILDING -- B. WING | 11/01/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 11/01/22<br><br>Facility Number: 000399<br>Provider Number: 15E683<br>AIM Number: 100289100<br><br>At this Emergency Preparedness survey, Morgantown Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 39 certified beds. At the time of the survey, the census was 32.<br><br>Quality Review completed on 11/02/22 | E 0000 | THIS PLAN OF CORRECTION IS PREPARED AND EXECUTED BECAUSE IT IS REQUIRED BY THE PROVISIONS OF THE STATE AND FEDERAL REGULATIONS AND CITATIONS LISTED ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION SHALL OPERATE AS MORGANTOWN;S WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE. MORGANTOWN HEALTH ARE RESPECTFULLY REQUEST PAPER COMPLIANCE ON THE THE ATTACHD PLAN OF CORRECTION. | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 11/01/22<br><br>Facility Number: 000399<br>Provider Number: 15E683<br>AIM Number: 100289100<br><br>At this Life Safety Code survey, Morgantown | K 0000 | THIS PLAN OF CORRECTION IS PREPARED AND EXECUTED BECAUSE IT IS REQUIRED BY THE PROVISIONS OF THE STATE AND FEDERAL REGULATIONS AND CITATIONS LISTED ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION SHALL OPERATE AS MORGANTOWN;S WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| DALE W. HARTMAN | HFA | 11/16/2022 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | Health Care was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility with a basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 39 and had a census of 32 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered.<br><br>Quality Review completed on 11/02/22 | | MORGANTOWN HEALTH ARE RESPECTFULLY REQUEST PAPER COMPLIANCE ON THE THE ATTACHD PLAN OF CORRECTION. | |
| K 0291 SS=F Bldg. 01 | NFPA 101<br>Emergency Lighting<br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.<br>18.2.9.1, 19.2.9.1<br>Based on record review, observation and interview; the facility failed to document monthly for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows:<br>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 | K 0291 | 1. CHECK LIST WAS GIVEN TO MAINTENACE TO BE COMPLETED ON 11/01/22.<br><br>2. ANY RESIDENT AS WELL AS STAFF AND VISITORS HAVE THE POTENTIAL TO BE AFFECTED. | 11/01/2022 |

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| | weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).<br>(2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.<br>(3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered.<br>(4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3).<br>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Morgantown Health Care-Inn Battery-Operated Emergency Lights-Test Log" documentation with the Maintenance man during record review from 9:52 a.m. to 12:40 p.m. on 11/01/22, monthly battery operated light testing had not been documented for the most recent twelve month period on the itemized by light location form. Based on interview at the time of record review, the Maintenance man stated he had been rehired on a part time basis in October 2021 and stated he has not filled out the 30 second monthly functional testing documentation for all battery operated lights in the facility for the most recent twelve month period. He also stated that he tests the emergency lights daily and makes a mark on the daily sheet, but it is not itemized by location. Based on observations with the Environmental Services Director and Maintenance man during a tour of the facility from 12:40 p.m. to 1:15 p.m. on 11/01/22, over 10 battery operated | | 3. ENVIORMENTAL SUPERVISOR, MAINTENANCE, ADMINISTRATOR WILL BE CHECKING THE DOCUMENTATION THAT ALL EMERGENCY LIGHTING HAS BEEN CHECKED DAILY AND MONTHLY. ENVIRONMENTAL SUPERVISOR WILL SET UP A BINDER FOR DAILY AND MONTHLY CHECK AS WEEL AS YEARLY AND THE MAINTENANCE MAN WILL HAVE A CCOMPLETE SET FOR HIS RECORDS, INSERVICE DON ON 11/1/22.<br><br>4. QAPI WILL RECEIVE A REPORT AT THE MONTHLY MEETING ANY RECOMMENDATIONS THAT QAPI HAS WILL BE FOLLOWED FOR 6 (SIX) MONTHS BY THE ENTIRE FACILITY.<br><br>5. DATE COMPLETED 11/1/22. | |

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| | lighting systems were noted in the facility and each battery operated light which could be tested functioned when its respective test button was pushed.<br><br>This finding was reviewed with the Administrator and Environmental Services Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0300<br>SS=F<br>Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in 20 of 20 resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review of "Smoke Detector Battery Change Log Sheet - Changed every six months or as needed" document on 11/01/22 between 9:52 a.m. and 12:40 p.m. with the | K 0300 | 1. BATTERIES (9 VOLT) FOR THE SMOKE DETECTORS WERE ORDERED FROM THE HARDWARE ON 11/1/22.<br><br>2. ALL RESIDENTS, STAFF OR VISITORS HAVE THE POTENTIAL TO BE AFFECTED.<br><br>3. MAINTENANCE SUPERVISOR, MAINTENANCE, ADMINISTRATOR WILL KEEP A SMOKE DETECTOR BATTERY LOG TO SHOW THAT HE BATTERIES HAVE BEEN CHANGED EVERY SIX MONTHS AS WELL AS A LOG WILL BE KEPT TO SHOW WHEN WE REPLACE A DETECTOR AS | 11/14/2022 |

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| | Maintenance man present, the documentation failed to indicate smoke alarm and/or battery replacement since 09/28/21. Based on interview at the time of record review, the Maintenance man stated he has replaced the batteries in the battery operated smoke detectors, but did not document when that occured. The Maintenance man confirmed that the last documented battery replacement was 9/28/21 on the form stating 'changed every six months or as needed'.<br><br>This finding was reviewed with the Administrator and Environmental Services Director during the exit conference.<br><br>3.1-19(b) | | WELL AS THE DATE OF REPLACEMENT. IN-SERVICE DONE ON 11/1/22.<br><br>4. QAPI WILL BE NOTIFIED AT THE MONTHLY MEETING AND THE FACILITY WILL FOLLOW THEIR RECOMMENDATIONS FOR 6 (SIX) MONTHS.<br><br>5. DATE COMPLETED 11/14/22. | |
| K 0363 SS=D Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is | | | |

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| | applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |
| | Based on observation and interview, the facility failed to ensure 1 of 20 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents.<br><br>Findings include:<br><br>Based on observation with the Environmental Services Director and Maintenance man on 11/01/22 during a tour of the facility at 1:00 p.m., the corridor door to resident room 19 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance man agreed the corridor door would not latch into the door frame, and would work on the door so it would latch. | K 0363 | 1.MAINTENANCE FILED DOWN THE LATCH OF THE DOOR FRAME IN ROOM 19.<br>2. ANY RESIDENT,STAFF,VISITORS HAS THE POTENTIAL TO BE AFFECTED.<br>3. MAINTENANCE SUPERVISOR,MANTENANCE,ADMINISTRATOR WILL MAKE SURE THAT ALL DOORS CLOSE PROPERLY ON A DAIY BASIS THROUGH OUT THE FACILITY, AND THE ENVIRONMENTAL SUPERVISOR WILL BE GIVEN A CHECK LIST SIGNED BY MAINTENANCE TAHT DOORS ARE CHECKED ON A DAILY BASIS, MONTHLY.<br>4. QAPI WILL BE NOTIFIED AT | 11/01/2022 |

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| | This finding was reviewed with the Administrator and Environmental Services Director at the exit conference.<br><br>3.1-19(b) | | THE MONTHLY MEETINGS AND ANY RECOMMENDATIONS WILL BE GOLLOWED BY FECILITY FOR 6 MONTHS. | |
| K 0741<br>SS=F<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br>1. Based on observation, records review, and interview, the facility failed to enforce 1 of 1 | K 0741 | 1. POLICY REWRITTEN 11/1/2022 AND INSERVICE | 11/15/2022 |

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| | smoking policies. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on records review with the Environmental Services Director and Maintenance man on 11/01/22 at 12:20 p.m., the smoking policy dated 05/01/2009 stated the facility is a smoke free facility and employees are not allowed to smoke on the property. Based on interview at the time of record review, the Environmental Services Director stated the facility is a non smoking facility. Based on observation upon arriving at the facility at 9:40 a.m., a female employee was smoking on the eastern side of the front porch of the facility. No smoking signs were observed attached to the building on the front porch. Based on observation with the Maintenance man during a tour of the facility on 11/01/22 between 12:40 p.m. and 1:15 p.m., the bottom section of a smoking tower that had over 20 cigarette butts in it and a plastic ashtray was sitting near the end of the ramp to the back door by two chairs. Based on interview at the time of observation, the Maintenance man confirmed that staff smoke in this location. 'No smoking' and 'No Smoking facility' signs were affixed to the outside of the facility by the back door. During the tour at 1:11 p.m., a female staff member was squatted down on the front porch of the facility and smoking a cigarette. The facility smoking policy stating employees are not allowed to smoke on property, that is located in the Disaster Preparedness binder that is reviewed on an annual basis, was reviewed with the Administrator and Environmental Services Director at the exit conference, and they confirmed that is the facility's policy.<br><br>2. Based on observation and interview; the facility | | COMPLETED 11/15/2022.<br>2. ANY RESIDENT, VISITOR,STAFF HAS THE POTENTIAL TO BE AFFECTED.<br>3. IN- SERVICE ON SMOKING POLICY WAS ON 11/15/2022 FOR EMPLOYEE STAFF. NEW SMOKING CONTAINER ORDERED FOR SMOKING DEBRIS. MAINTENANCE SUPERVISOR,MAINTENANCE,ADMINISTRATOR WILL CHECK DAILY ON THE AREA SPECIFIED AS SMOKING AND MAKE SURE THE SMOKING POLICY IS ADHERED TOO AND THAT THE AREA IS FREE OF SMOKING DEBRIS.<br>4 QAPI WILL BE NOTIFIED IN THE MONTHLY MEETING AND THEIR RECOMMENDATIONS WILL BE FOLLOWED BY THE FACILITY FOR 6 MONTHS. | |

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| | failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff by the back door.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance man on 11/01/22 at 12:55 p.m., the bottom section of a smoking tower that had over 20 cigarette butts in it and a plastic ashtray was sitting near the end of the ramp to the back door by two chairs. Based on interview at the time of observation, the Maintenance man confirmed that staff smoke in this location and agreed cigarette butts were not deposited into ashtrays and/or metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design at this outdoor location where smoking was taking place.<br><br>This finding was reviewed with the Administrator and Environmental Services Director during the exit conference.<br><br>3.1-19(b) | | | |
| K 0920<br>SS=E<br>Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for | | | |

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| | non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect up to 10 residents, as well as 2 staff and 2 visitors.<br><br>Findings include:<br><br>Based on observation during a tour of the facility on 11/01/22 at 1:03 p.m. with the Environmental Services Director and Maintenance man, a multi-plug adapter (two outlet to six outlet) was in use in the Activities office off the dining room. Plugged into the multi-plug adapter was a microwave, a dorm-sized refrigerator, a coffee machine and a large fan. Based on interview at the time of the observations, the Environmental Services Director confirmed the use of a | K 0920 | 1. MULTI-PLUG IN THE SOCIAL SERVICE OFFICE WAS REMOVED IMMEDIATELY.<br>2. ANY RESIDENT,VISITOR,STAFF HAS THE POTENTIAL TO BE AFFECTED.<br>3. ENVIRONMENTAL SUPERVISOR,MAINTENANCE,ADMINISTRATOR WILL CHECK ON A DAILY BASIS THAT PROPER EQUIPMENT IS USED IN THE FACILITY AS FAR AS ELECTRICAL PLUG IN AND IN ACCORDANCE WITH NFPA70, NATIONAL ELECTRICAL CODE. ENVIRONMENTAL SUPERVISOR WILL REVIEW REPORT MONTHLY THAT ELECTRICAL CODE IS ADHERED TOO BY ALL STAFF AND RESIDENTS FROM MAINTENANCE.<br>4. QAPI WILL BE GIVEN A REPORT AT MONTHLY | 11/01/2022 |

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| MORGANTOWN HEALTH CARE | 140 W WASHINGTON ST<br>MORGANTOWN, IN 46160 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | multi-plug adapter and stated that she was not aware that extension cords were not to be used as a substitute for fixed wiring.<br><br>This finding was reviewed with the Administrator and Environmental Services Director at the exit conference.<br><br>3.1-19(b) | | MEETINGS AND FACILITY WILL FOLLOW RECOMMENDATIONS OF QAPI FOR 6 MONTHS. | |