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 _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORGANTOWN HEALTH CARE	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 IN00217086. Complaint IN00217086 - Unsubstantiated due to lack of evidence. Survey date: January 9 and 10, 2017 Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census bed type: NF: 37 Total: 37 Census payor type: Medicaid: 35 Other: 2 Total: 37 Sample: 03 Morgantown Health Care 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 IN00217086. QR was completed by 99993 on 01/11/17.	F 000		

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