

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 12/17/2025
NAME OF PROVIDER OR SUPPLIER Morgantown Woods of Journey		STREET ADDRESS, CITY, STATE, ZIP CODE 140 W Washington St Morgantown, IN 46160	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse when a male resident punched another male resident in the face for 1 of 3 residents reviewed for abuse. (Resident B, Resident C) Findings include: On 12/17/25 at 8:14 a.m., the Administrator provided a copy of a facility reportable incident, dated 12/1/25 at 6:05 p.m. A review of the facility reportable incident indicated Resident B had been agitated the entire day and displayed verbal and physical aggression toward staff. Resident C had been experiencing an episode of psychosis, had not been easily redirected, and had displayed numerous psychotic behaviors over the previous several days. Staff observed Resident B make contact with Resident C's face with a closed fist. During an interview on 12/17/25 at 8:23 a.m., Qualified Medication Aide (QMA) 1 indicated, on 12/1/25 at approximately 6:00 p.m., she walked to the front of the facility near the kitchen and heard a loud noise. When she looked in the direction of the noise, QMA 1 witnessed Resident C sitting on a bench in the front lobby area. Resident B was standing in front of Resident C punching Resident C in his face with a right closed fist. QMA 1 was not able to count the number of times Resident C was punched by Resident B, but that it was multiple times. The two residents were immediately separated. A small, bluish-purple, swollen area was observed under Resident C's right eye. Resident C indicated his eye hurt and QMA 1 got ice to apply to Resident C's right eye. Resident B had been aggressive toward residents in the past. The clinical record for Resident C was reviewed on 12/17/25 at 9:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, schizophrenia, and anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 11/28/25, indicated Resident C was cognitively intact. A progress note, dated 12/1/25 at 6:05 p.m., indicated Resident C had a small bruise under his right eye that measured 1 centimeter (cm) by 0.6 cm with a small cut and was the result of Resident B punching Resident C. The clinical record for Resident B was reviewed on 12/17/25 at 9:30 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and depression. A quarterly MDS assessment, dated 9/3/25, indicated Resident B was severely cognitively impaired. A progress note, dated 12/1/25 at 6:10 p.m., indicated Resident B was physically and verbally aggressive and punched Resident C in the face multiple times. On 12/17/25 at 9:45 a.m., the Administrator provided a copy of a facility policy, dated 3/5/24, and indicated this was the policy currently used by the facility. A review of the policy indicated it was the policy of the facility to prevent abuse. This citation relates to Intake 2681931.3.1-27(a)(1)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 15E683
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