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	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Woods of Journey	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 35318 Based on observation, interview, and record review, the facility failed to protect the residents right to be free from physical restraints for 3 of 5 residents reviewed for restraints. Documentation of releasing the restraint and repositioning was not completed and informed consent for the use of restraints was not completed prior to placing the resident in restraints. (Resident 3, Resident 16, Resident 27) Findings include: 1. On 6/26/24 at 2:11 p.m., Resident 16 was observed sitting in a broda chair asleep in the hallway with lap straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 9:10 a.m., Resident 16 was observed sitting in the broda chair asleep in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 10:24 a.m., Resident 16 was observed sitting in the broda chair asleep in her room with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 11:29 a.m., Resident 16 was observed sitting in the broda chair asleep in her room with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 12:28 p.m., Resident 16 was observed sitting in the broda chair awake in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 2:00 p.m., Resident 16 was observed sitting in the broda chair awake in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 7/1/24 at 10:19 a.m., Resident 16 was observed sitting in the broda chair awake in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 7/1/24 at 12:12 p.m., Resident 16 was observed sitting in the broda chair awake in her room with leg straps around her legs to prevent her from getting out of the chair. On 7/1/24 at 2:56 p.m., Resident 16 was observed sitting in the broda chair awake in her room with leg straps around her legs to prevent her from getting out of the chair. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 16's clinical record was reviewed on 6/28/24 at 9:30 a.m. The diagnoses included, but were not limited to, progressive supranuclear ophthalmoplegia (slow and difficult muscle movements) and anxiety disorder. Physician orders, dated 7/2/24, for Resident 16 indicated, . broda/geri chair with tray while up due to leaning to sides and forward, unable to maintain direct torso . The physician orders did not indicate using leg restraints when resident was sitting in the broda chair. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, assessed Resident 16 as using limb restraints daily. A care plan, initiated on 8/9/23, and current through target date 6/12/24, for Resident 16 indicated, . Problem: Resident requires use of broda chair with straps while up due to inability to maintain erect torso . Goal: Resident will be free from negative outcomes or decline in functioning relative to restraint use . Interventions: 9. Release every 2 hours and prn [as needed] to reposition and toilet . The Informed Consent for Use of Restraints form, dated 5/8/24, for Resident 16 indicated, . broda chair with leg straps . release and reposition every 2 hours and when toileting . A review of the clinical record for Resident 16 lacked documentation of where the resident was released and repositioned every 2 hours while up in the broda chair with leg straps. 2. On 6/27/24 at 10:43 a.m., Resident 3 was observed sitting in a broda chair awake in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 9:12 a.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 10:25 a.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 11:28 a.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 1:59 p.m., Resident 3 was observed sitting in a broda chair awake in his room with lap straps around his legs to prevent him from getting out of the chair. On 7/1/24 at 10:20 a.m., Resident 3 was observed sitting in a broda chair awake in his room with lap straps around his legs to prevent him from getting out of the chair. On 7/1/24 at 2:59 p.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. Resident 3's clinical record was reviewed on 7/1/24 at 10:25 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and traumatic brain injury. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders, dated 7/2/24, for Resident 3 indicated, . broda chair with straps to be utilized while up due to inability to maintain erect torso, leans to side and forward . The Annual Minimum Data Set (MDS) assessment, dated 6/5/24, assessed Resident 3 as using limb restraints daily. A care plan, initiated on 9/1/23, and current through target date 5/13/24, for Resident 3 indicated, . Problem: Resident requires use of broda chair while up due to inability to recall he is unable to bear his own weight . Goal: Resident will be free from negative outcomes or decline in functioning relative to restraint use . Interventions: 9. Release resident every 2 hours and prn for toileting and repositioning . The Informed Consent for Use of Restraints form, dated 6/29/24, for Resident 3 indicated, . broda chair with straps . release and reposition every 2 hours and when toileting . The consent form was dated after the resident was observed to be in a broda chair with leg restraints. A review of the clinical record for Resident 3 lacked documentation of where the resident was released and repositioned every 2 hours while up in the broda chair with leg straps. During an interview on 7/2/24 at 11:48 a.m., the Director of Nursing indicated the facility did not have a consent prior to the 6/29/24 date for Resident 3's use of restraints. 3. On the following dates, times, and locations, Resident 27 was observed sitting in a Broda wheelchair (a chaired designed to provide supportive positioning, decrease postural deviations, and enhance patient safety while facilitating safe, frequent repositioning) with restraining straps secured across the resident's upper legs. The straps were unable to be removed by the resident: - On 6/26/24 from 9:40 a.m. to 11:55 a.m., Resident 27 was observed to be straining against the restraints and emitting a high pitched vocal sound in her room. - On 6/26/24 from 1:20 p.m. to 3:30 p.m., in her room. - On 6/27/24 from 9:30 a.m. to 12:15 p.m., Resident 27 was observed to be straining against the restraints in her room. - On 6/28/24 from 10:00 a.m. to 12:35 p.m., in her room. - On 6/28/24 from 2:05 p.m. to 3:25 p.m., Resident 27 was observed to be straining against the restraints and emitting a high pitched vocal sound in her room. - On 7/1/24 from 9:31 a.m. to 11:47 a.m., in her room. - On 7/1/24 from 1:00 p.m. to 3:15 p.m., in her room. - On 7/2/24 at 9:05 a.m., in the dining room. - On 7/2/24 at 11:40 a.m., Resident 27 was observed to be straining against the restraints and emitting a high pitched vocal sound in her room. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no observations of the resident being removed from restraints or pacing during the survey time period. On 7/1/24 at 11:50 a.m., Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified mood disorder and dementia. Physician's orders with a start date of 5/31/24 through the current date indicated, Broda chair with straps while up for safety and positioning, unable to maintain erect torso. Paces to the point of exhaustion and unaware of her environment. Release and reposition every two hours and as needed. There was no documentation indicating the resident was released from the restraint every 2 hours and there was no documentation identifying any type of specific direct monitoring and supervision provided during the use of the restraint. A care plan with a review start date of 6/14/24 and a target date of 7/6/24 indicated the resident was to be released from the restraint and repositioned every 2 hours. During an interview on 7/2/24 at 9:00 a.m., CNA 1 indicated she was not certain how often the resident was to be out of the restraint but believed it was fairly frequently. During an interview on 7/2/24 at 9:30 a.m., CNA 2 indicated she was not certain how often the resident was to be out of the restraint, and on evening shift staff released the restraint and walked with the resident, as the resident enjoyed walking. During an interview on 7/2/24 at 1:16 p.m., the DON indicated the clinical record did not indicate Resident 3, Resident 16, and Resident 27 were released from their restraints and repositioned every 2 hours. On 7/1/24 at 1:15 p.m., the Administrator provided the facility's policy,Restraint Free Environment dated 3/1/24, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate to complete documentation of where the resident was repositioned or released every 2 hours while in restraints nor having an Informed Consent for Use of Restraint formed signed prior to placing the resident in restraints. 3.1-26(h)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34848 Based on observation and interview, the facility failed to ensure the daily posted nurse staffing reflected the actual hours worked by staff for 5 of 5 days of daily posted nurse staffing reviewed. Findings include: On 6/26/24 at 11:42 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/27/24 at 10:26 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/28/24 at 9:28 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 7/1/24 at 10:49 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 7/2/24 at 10:20 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. During an interview on 7/2/24 at 11:37 a.m., the Clinical Support Nurse indicated the facility should be including actual hours worked on the staffing sheet and be updated the following day to reflect the actual hours worked by licensed staff. They indicated the facility did not have a policy in regard to specific requirements on the nurse staffing sheets.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34848 Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed. As needed antipsychotic medications were prescribed for longer than 14 days, gradual dose reductions (GDR) were not completed, and antipsychotic medications did not have an adequate diagnosis. (Resident 3) Findings include: During an observation on 6/27/24 at 9:49 a.m., Resident 3 was observed sitting upright in a broda chair with lower limb restrains in place. The resident repeatedly shouted, Come here!, in a loud and intelligible voice. On 6/27/24 at 10:17 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, personal history of traumatic brain injury, insomnia, and anxiety. A 5/9/24 physician's order indicated the resident was prescribed olanzapine (antipsychotic medication) 2.5 milligrams, two times a day, related to Alzheimer's disease and prochlorperazine maleate (antiemetic and antipsychotic medication) 1 tablet by mouth every six hours as needed for nausea and vomiting. An Annual Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident had a diagnosis of Alzheimer's disease and used antipsychotic medication. The MDS assessment also indicated a GDR was not attempted and was not clinically documented as contraindicated. A Psychotropic and Sedative/Hypnotic Utilization by Resident, for records updated between 2/1/24 and 2/8/24, included, but was not limited to: - Zyprexa (olanzapine) 2.5 mg twice a day for dementia diagnosis ordered 4/18/22, next evaluation 2/2024. - Prochlorperazine maleate 10 mg every six hours as needed for nausea and vomiting, ordered 10/4/23, next evaluation 1/2024. The clinical record lacked an evaluation for the continued use of as needed antipsychotics, adequate diagnosis for antipsychotics, and attempted GDR for psychotropic medications. During an interview on 7/2/24 at 2:30 p.m., the Clinical Support Nurse indicated resident should not have a antipsychotic medication for dementia without behaviors. She further indicated she believed the resident's hospice care would be an indicator for not attempting a GDR for as needed antipsychotics. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 3:30 p.m., the Administrator provided the facility policy, Gradual Dose Reduction of Psychotropic Drugs, revised on 2/14/24, and indicated it was the policy currently being used. A review of the policy indicated, . GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. Psychotropic Drug is defined as any drug that affects brain activities associated with mental process and behavior . 4. The timeframes and duration of attempts to taper any medication . c. Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or otherwise modified include: i. During the monthly medication regime review by the pharmacist. ii. When the physician or prescribing practitioner evaluated the resident's progress . 3.1-48(a)(3) 3.1-48(b)(2)