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	04/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50647 Based on observation, interview, and record review, the facility failed to maintain resident's dignity while assisting residents with the meal for 2 of 2 dining observations. Staff stood while assisting the resident. (Resident 27) Findings include: During a dining room observation on 4/7/25 at 12:23 p.m. until 12:40 p.m., CNA 1 was observed to stand to the left of Resident 27 to assist the resident with the meal. CNA 1 then placed her hand on the forehead of Resident 27 to hold her head up while she placed a spoon in the resident's mouth. CNA 1 did not talk with Resident 27, she was observed to talk with other staff members while they assisted residents during the noon meal. During an observation on 4/8/25 at 12:20 p.m., Resident 27 was observed eating with assistance of the Activity Director (AD). The AD was observed to be standing in front of the resident while assisting with the meal. On 4/8/25 at 1:39 p.m., Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and psychosis (when people lose some contact with reality). The Quarterly Minimum Data Set (MDS) assessment, dated 3/15/25, indicated no BIMS (Brief Interview for Mental Status) score. An ADL (Activities of Daily Living) care plan (revised on 12/23/24), indicated the resident had an ADL self-care performance deficit related to dementia. The care plan indicated that the resident was dependent on staff for assistance with meals. During an interview on 4/9/25 at 1:55 p.m., CNA 3 indicated Resident 27 required total assistance with meals. CNA 3 indicated that while assisting residents with meals, staff should not stand while assisting with meals, and should engage residents not other staff. On 4/9/25 at 3:52 p.m., the DNS (Director of Nursing Services) provided a copy of Resident Rights (undated), she indicated this was a policy currently being used in the facility. A review of the Resident's Rights indicated . Right of dignified existence: Be treated with consideration, respect and dignity, recognizing each resident's individuality, .A home-like environment . (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(t)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38312 Based on observation, interview, and record review, the facility failed to communicate the resident's choice of advance directive to the staff responsible for the resident's care for 1 of 1 residents reviewed for Advance Directive. (Resident 186) Findings include: On [DATE] at 2:28 p.m., Resident 186's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), left side hemiplegia (paralysis on one side), and schizophrenia. Resident 186's admitted was [DATE]. The clinical record lacked documentation of the Indiana Physician Orders for Scope of Treatment (POST) form. During an interview on [DATE] at 10:55 a.m., the Director of Nursing (DNS) indicated Social Services would complete the POST form on admission, the nurse practitioner would review and sign, and then scan the POST form into the electronic health record (EHR) with a copy going in a binder at the nurse's station. The DNS could not locate the POST form in the EHR. With the DNS, the binder at the nursing station was observed to lack Resident 186's POST form. On [DATE] at 11:14 a.m., the DNS presented the POST form, dated [DATE]. The POST form indicated Resident 186 requested Cardiopulmonary Resuscitation (CPR) and full medical attention. At that time, she indicated it was in the scanned pile which was not at the nursing station. On [DATE] at 3:53 p.m., the DNS provided the facility's policy, Residents' Rights Regarding Treatment and Advance Directives, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff . 3XXX,d+[DATE](f)(5)

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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. 50647 Based on observation, interview, and record review, the facility failed to protect the residents right to be free from physical restraints for 1 of 3 residents reviewed for restraints. Documentation of re-evaluation of the need for restraints was not completed. (Resident 27) Findings include: On 4/7/25 at 11:35 a.m., Resident 27 was observed sitting in a Broda chair awake in the hallway with leg straps over both legs to prevent her from getting out of the chair. On 4/7/25 at 2:40 p.m., Resident 27 was observed sitting in a Broda chair asleep in her room with leg straps over both legs to prevent her from getting out the chair. On 4/8/25 at 9:32 a.m., Resident 27 was observed sitting in a Broda chair asleep in her room with leg straps over both legs to prevent her from getting out of the chair On 4/8/25 at 10:00 a.m., Resident 27 observed sitting in a Broda chair in her room. Two patient care staff members released and repositioned the leg straps at that time. On 4/9/25 at 11:08 a.m., Resident 27 observed sitting in a Broda chair asleep in her room with leg straps over both legs to prevent her from getting out of the chair. On 4/9/25 at 11:40 a.m., two patient care staff were observed in Resident 27's room with the resident, they released and repositioned leg straps. Resident 27's clinical record was reviewed on 4/8/25 at 1:39 p.m. The diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease (COPD), anxiety, and psychosis (when people lose some contact with reality). A physician order, dated 5/31/24, 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 2 hours and as needed. Review quarterly and as needed for continued use of Broda Chair requirements . The Quarterly Minimum Data Set (MDS) assessment, dated 3/15/25, lacked documentation for daily use of limb restraints. A Care Plan, revised 3/26/25, indicated, Broda chair with straps while up for safety and positioning. The Informed Consent for Use of Restraints, dated on 5/9/24 for Resident 27 indicated, .Broda Chair with leg straps to prevent resident from falling out of chair . The document lacked recommended duration and release and reposition schedule. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Adaptive Device Review, dated 1/31/25 for Resident 27 indicated, .device initiated on 5/31/24, . Medical reason for use: unable to maintain erect torso .Rationale for continued use of restrictive device: positioning . The clinical record lacked any previous quarterly reviews. During an interview with the DNS (Director of Nursing Services) on 4/9/25 at 3:20 p.m., the DNS indicated there were no further evaluations completed on Resident 27. She indicated evaluations should be completed quarterly for re-evaluation of continued need of restraint use. On 4/9/25 at 3:52 p.m., the DNS provided the facility's policy, Restraint Free Environment dated 7/15/24, and indicated it was a policy currently being used by the facility. A review of the policy indicated .6 .The resident's record needs to include documentation .ongoing re-evaluation of the need for the restraint . 3.1-26(r) 3.1-26(s)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 35318 Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set assessment for 4 of 12 residents reviewed. The admission from location, daily use of limb restraints, anticoagulant medications, and prognosis were coded incorrectly. (Resident 35, Resident 27, Resident 18, Resident 1). Findings include: 1. Resident 35's clinical record was reviewed on 4/8/25 at 11:24 a.m. The diagnosis included, but was not limited to, Alzheimer's Disease. Resident 35's admitted was 1/15/25. A review of nursing progress notes indicated Resident 35 had been staying with his sister in another state but had recently moved back to this area to be closer to where his brother lived. Resident 35's Admission Minimum Data Set (MDS) assessment, dated 1/28/25, indicated the resident had admitted from a nursing home. During an interview on 4/8/25 at 11:32 a.m., the Administrator indicated the resident had been living out of state with his sister prior to being admitted to the facility. During an interview on 4/8/25 at 1:58 p.m., the MDS Coordinator indicated the Admission MDS assessment for Resident 35 was incorrect because the resident had admitted from home after living with his sister. A review of the RAI,Version 3.0 User's Manual, on 4/9/25 at 3:30 p.m., indicated . A1805 Code 01: Home/Community: if the resident was admitted from a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly . 50647 2. Resident 27's clinical record was reviewed on 4/8/25 at 1:39 p.m. The diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease (COPD), anxiety, and psychosis (when people lose some contact with reality). A physician order, dated 5/31/24, 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 2 hours and as needed. Review quarterly and as needed for continued use of Broda Chair requirements . The Quarterly MDS assessment, dated 3/15/25, lacked documentation for daily use of limb restraints. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant Director of Nursing Services (ADNS)/ MDS Coordinator on 4/9/25 at 2:00 p.m., she indicated that the resident used limb restraints daily while in the Broda chair and the MDS assessment should have been coded to reflect that. A review of the RAI,Version 3.0 User's Manual, on 4/9/25 at 3:00 p.m., indicated .P0100: Physical Restraints . Review the resident's medical record .to determine if physical restraints were used during the 7-day look-back period . 3. Resident 18's clinical record was reviewed on 4/8/25 at 12:02 p.m. The diagnoses included, but were not limited to, COPD, dementia and schizophrenia (affects a person's ability to think, feel, and behave clearly). A physicians order, dated 8/17/24, indicated Eliquis Oral Tablet 2.5 MG (a medication to prevent and treat blood clots), give 1 tablet by mouth two times a day. The order was discontinued on 2/19/25. The Quarterly MDS assessment, dated 3/8/25, indicated resident's medication included an anticoagulant (a medication that reduce the blood's ability to clot, preventing or slowing down the formation of blood clots). During an interview with the Assistant Director of Nursing Services (ADNS)/ MDS Coordinator on 4/9/25 at 2:00 p.m., she indicated that the resident was not taking an anticoagulant at the time of the Quarterly MDS assessment and it should have been coded no. A review of the RAI,Version 3.0 User's Manual, on 4/9/25 at 3:00 p.m., indicated .Item N0415, High-Risk Drug Classes: Use .Review the resident's medical record for documentation that any of these medications were received by the resident .during the 7-day lookback period . 34848 4. Resident 1's clinical record was reviewed on 4/6/25 at 10:34 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's disease, and dementia. A 12/27/24 quarterly MDS assessment, indicated the resident did not have a life expectancy of less than 6 months for section J1400: Prognosis. A 3/15/24 physician's order indicated the resident was admitted to hospice care on 3/15/24. During an interview on 4/9/25 at 2:35 p.m., the MDS coordinator indicated she normally coded the MDS assessments as 'no' because she was taught to do so. She further indicated the Resident Assessment Instrument (RAI) manual was accessible to her when she completed the MDS assessments. During an interview on 4/9/25 at 3:52 p.m., the DNS indicated the facility did not have a policy related to MDS coding and the facility followed the RAI manual for coding purposes. On 4/10/25 at 11:56 a.m., a review of the Center for Medicare and Medicaid Long-Term Care Facility Resident Assessment Instrument, dated October 2024, indicated, . J1400: Prognosis . Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-31(d)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38312 Based on observation, interview, and record review, the facility failed to ensure the sanitation bucket in the kitchen was at the correct level required for 1 of 1 sanitation bucket reviewed during the kitchen initial tour. This has the potential to affect 35 of 35 residents served from the kitchen. Findings include: During the initial kitchen tour on 4/7/25 at 10:15 a.m., the Assistant Dietary Manager tested the sanitizing solution in the sanitation bucket on the three compartment sink. She used the test strip and dipped the strip in the sanitizing solution. She read the test strip color to the color chart on the bottle which indicated it was 170. She was unsure what color on the test strip bottle, the test strip should of been. On 4/7/25 at 10:36 a.m., the Assistant Dietary Manager indicated the sanitizing solution was low. It should of been 272-700. On 4/9/25 at 4:15 p.m., the Regional Registered Dietician provided the facility's policy, The Sanitizing Buckets, revised 3/31/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .1. Cleaning and sanitizing buckets will be prepared at the start of each shift and replaced as needed in order to maintain proper concentration of cleaning/sanitizing solution . 3.1-21(i)(2) 3.1-21(i)(3)