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	03/11/2026

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to ensure a quarterly Minimum Data Set (MDS) assessment was completed 92 days after the previous MDS assessment for 2 of 3 residents reviewed for Resident Assessment. (Resident 2, Resident 24)Findings include: 1. On 3/10/26 at 11:43 a.m., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension. The quarterly MDS assessment was dated 10/3/25. The clinical record lacked documentation of another assessment since 10/3/25. 2. On 3/10/26 at 11:50 a.m., Resident 24's clinical record was reviewed. The diagnoses included, but were not limited to, schizoaffective disorder and anxiety. The quarterly MDS assessment was dated 10/3/25. The clinical record lacked documentation of another assessment since 10/3/25. During an interview on 3/11/26 at 12:04 p.m., the Corporate MDS nurse indicated Resident 2 and Resident 24's clinical record lacked documentation of a quarterly MDS assessment since 10/3/25. On 3/11/26 at 2:49 p.m., the Administrator provided the facility policy, Assessment Frequency/Timeliness, dated 2/1/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .4. A quarterly review assessment will be completed no less than once every 3 months. It must be completed within 92 days of the ARD [assessment reference date] of the most recent OBRA [Omnibus Budget Reconciliation Act] assessment. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(d)(3)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure Minimum Data Set Assessments were accurate for 2 of 14 residents reviewed for comprehensive assessment. (Resident 5, Resident 29) Findings include:1. On 3/10/26 at 11:05 a.m., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder and anxiety disorder. The Preadmission Screening and Resident Review (PASARR), dated 9/14/19, indicated the resident had serious mental illness. Current physician's orders indicated the resident was taking Torsemide (a diuretic) beginning on 7/12/25 and Depakote (an anticonvulsant) beginning on 7/11/25. The annual Minimum Data Set (MDS) Assessment, dated 8/11/25, indicated the resident did not have a serious mental illness and was not taking diuretic or anticonvulsant medications. During an interview on 3/11/26 at 1:50 p.m., the Director of Nursing indicated the 8/11/25 annual MDS assessment was incorrectly coded. 2. On 3/10/26 at 11:53 a.m., Resident 29's clinical record was reviewed. The diagnoses included, but were not limited to, schizoaffective disorder, depression, and anxiety. The Preadmission Screening and Resident Review (PASARR), dated 2/12/20, indicated Resident 29 had a Level 2 related to serious mental illness. The annual Minimum Data Set (MDS) assessment, dated 8/21/25, indicated no Level 2 was completed. During an interview on 3/11/26 at 12:04 p.m., the Corporate MDS nurse indicated Resident 29's annual MDS was incorrect. On 3/11/26 at 2:49 p.m., the Administrator provided the facility policy, Conducting an Accurate Resident Assessment Policy, dated 2/1/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status . 410 IAC (Indiana Administrative Code) 16.2-3.1-31(d)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure a resident had an accurate Level I Preadmission Screening and Resident Review (PASARR) for 1 of 3 residents reviewed for PASARR. (Resident 24)Findings include: On 3/10/26 at 10:08 a.m., Resident 24's clinical record was reviewed. The diagnoses included, but were not limited to, schizophrenia and anxiety. Resident 24's PASARR, dated 3/3/25, indicated no Level II required due to no serious mental illness, no mental health symptoms, and no antidepressants or any other mental health medication were prescribed. There was no evidence of a PASARR condition of a serious mental health condition. If changes occur or new information refutes these findings, a new screen must be submitted. Resident 24's admission date was 3/31/25 with the diagnosis of schizophrenia and a diagnosis date of anxiety was 4/17/25. The Order Summary Report dated 3/11/26 indicated the following:- Buspirone (antianxiety medication) 15 milligrams (mg) give a 0.5 tablet twice a day for anxiety, start date 1/9/26. - Paroxetine (antidepressant medication) 30 mg give one table one time a day, start date 3/6/26. During an interview on 3/11/26 at 10:45 a.m., the DON (Director of Nursing) indicated Resident 24's Level 1 was completed prior to his admission to the facility and no new Level 1 had been completed since his admission. On 3/11/26 at 2:49 p.m., the Administrator provided the facility policy, Preadmission Screening and Resident Review Policy, revised date 3/11/26, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .9. The Administrator and Director of Nursing will monitor compliance with PASARR requirements through periodic audits of admissions and resident records .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive care plan related to noncompliance for 1 of 14 residents reviewed for care plans. (Resident 39)Findings include:On 3/9/26 at 2:58 p.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), hypertension, dementia, diabetes mellitus with circulatory complications, and heart failure. A Physician's Order, dated 6/2/24, indicated the resident was prescribed a 2,000 cc (cubic centimeters; equivalent to 1 milliliter) fluid target goal, with 480 cc at breakfast, 480 cc at lunch, 480 cc at dinner, 120 cc each shift, and 120 cc at bedtime. The resident's progress notes indicated the following: - On 12/8/25 at 2:42 p.m., the resident had frothy sputum and asked for 8-10 mugs of ice in one shift. He was educated he was not to have more than 2 mugs of ice per shift. - A Dietitian Evaluation, dated 12/29/25, indicated the resident did not adhere to his prescribed fluid restriction diet and occasionally consumed in excess of the fluid goal. - On 1/13/26 at 9:10 p.m., the resident refused to follow his fluid restriction. - On 1/21/26 at 11:14 a.m., the resident had coffee and less than 15 minutes later he asked for ice. When he was reminded of his fluid restriction, he became angry and shook his walker at staff. - On 1/26/26 at 11:52 a.m., the resident refused to adhere to his fluid restriction goals regardless of repeated education on extra fluid and respiratory status. - On 1/30/26 at 11:30 a.m., the resident was educated on his fluid target goal. He denied an understanding and demanded water and drinks. His roommate gave him water. He was provided education to the possible side effected of CHF (heart failure) exacerbation, he stated he understood, but he wanted the water anyway. The clinical record lacked a comprehensive person-centered care plan related to Resident 39's noncompliance with the prescribed fluid restriction. During an interview on 3/10/26 at 3:25 p.m., QMA 2 indicated the resident was noncompliant with the ordered fluid restriction. They offered him ice chips to slow him down, but he was constantly begging staff for water, saying he was always thirsty, and his roommate would give him water. They educated him each time, but it did not work. On 3/11/26 at 3:15 p.m., the Director of Nursing (DON) was asked to provide a care plan which addressed the resident's fluid restriction noncompliance, and she provided two care plans titled, [Resident's name] has coronary artery disease (CAD) related to atherosclerosis. He was recently in the ER for mild pulmonary congestion and fluid overload, initiated on 5/7/24, and [Resident's name] has behavior problems of using attention seeking behaviors of pressing that (sic) call light continuously just to pick something up off of the floor, or to grab some that (sic) is in reach for him, he also will yell very loudly HELP instead of pressing the call light, when he doesn't need anything but a cup of ice or the television changed. When resident is redirected or reeducated he will get agitated, initiated on 3/21/25. During an interview at that time, the DON indicated the care plans did not directly address his fluid restriction noncompliance.410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(2)