| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185006 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Morgantown Care & Rehabilitation Center | 201 South Warren Street<br>Morgantown, KY 42261 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to inform the resident or resident representative and/or provide written information to all residents regarding the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. This affected 6 of 29 sampled residents, Resident (R)8, R22, R45, R63, R110, and R123. The findings include:Review of the facility policy titled, Advance Directives, last revised [DATE], revealed the facility would ensure each resident had the right to request, refuse and/or discontinue treatment; participate in or refuse to participate in experimental research; and formulate an advance directive. Continued review revealed an advance directive was written with instruction, such as a living or durable power of attorney for healthcare, recognized under state law, relating to the provision of healthcare when the individual was incapacitated. Additional review of the facility policy titled, Advance Directives, revealed during the admission process, the facility would attempt to determine whether the resident had an advance directive, and if not, determine whether the resident wished to formulate an advance directive. Information would be provided in a manner easily understood by the resident or resident representative about the right to refuse medical or surgical treatment and formulate an advance directive. Additionally, the facility would periodically review, as part of the comprehensive care planning process, the existing care instructions and whether the residents or representative, as appropriate, wished to change or continue these instructions. The facility documented and communicated the residents' choices to the interdisciplinary team and to staff responsible for the resident's care as applicable and appropriate.Review of the Kentucky Medical Orders for Scope of Treatment (MOST form) revealed a patient was not required to complete the MOST form. A patient with capacity or their legal representative may void a form at any time by communicating that intent to the healthcare provider. Any section not completed does not invalidate the form and implies full treatment for that section. Continued review revealed once initial medical treatment began and the risks and benefits of further therapy were clear, treatment wishes may change medical care and this form can be changed to reflect new wishes at any time. Continued review revealed no form can address all the medical treatment decisions that may need to be made, and advance directives such as the Kentucky Healthcare Power of Attorney was recommended for all capable adults, regardless of their health status. Additional review of the Kentucky Medical Orders for Scope of Treatment (MOST form), revealed an advance directive allows you to document in detail your future healthcare instructions or name a surrogate to speak for you if you are unable to speak for yourself or both. If there are conflicting directions between an enforceable living will and a MOST form, the provisions of the will shall prevail. Further review revealed the MOST form must be reviewed and signed by the patient's physician. The MOST form must be reviewed and contain the original signature of the patient's physician to be valid. The signature of the patient surrogate or responsible party is required; however, if the patient surrogate or responsible party is not reasonably available to sign the original form, a copy of the completed form with the signature or electronic signature of the patient, surrogate or responsible party must be signed by the patient's physician and<br>(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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | placed in the medical record. The MOST must be reviewed at least annually, at any time the patient or patient's representative requests, when the patient is admitted or discharged from a healthcare facility, and when there is a substantial change in the patient's health status or a change in the patient's treatment preference.Review of the Resident Legal Document Checklist, located in the admission Agreement, revealed a box indicating the document type the resident or representative provided and a box that stated check all that apply. The document types included power of attorney, healthcare proxy, healthcare surrogate guardianship order, living will, and advance directive. Further review of the checklist revealed a signature line for the person named to act on the resident's behalf as the legal authority and a signature line for the resident and/or the resident's authorized legal representative.1. Review of R8's Face Sheet located in the Electronic Medical Record (EMR), revealed the facility admitted the resident on [DATE] with diagnoses including type 2 diabetes mellitus with hyperglycemia. Review of the facility document titled Resident Legal Document Checklist, dated [DATE] and signed by R8, revealed no indication the resident had a Power of Attorney, Health Care Proxy, Health Care Surrogate, Guardian, Living Will, Advance Directive or other. The box to check all that apply was blank. Therefore, the document was incomplete.Review of R8's Kentucky Medical Orders for Scope of Treatment (MOST) form, dated [DATE], revealed the form was voluntary and could be voided at any time. Any section not completed did not invalidate the form and implied full treatment for that section. Further review of R8's MOST form revealed section A indicated Attempt Cardio-Pulmonary Resuscitation (CPR) and section B indicated full treatment. Additional review revealed section C related to antibiotics, and section D related to Intravenous fluids had not been completed. Review of R8's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a 15 out of 15, indicating intact cognition. Review of R8's medical record revealed no documented evidence of an advance directive.In an interview with R8, on [DATE] at 2:54 PM, he stated he did not recall being asked about nor was he provided with information about a living will or an advance directive.2. Review of R22's Face Sheet, located in the EMR, revealed the facility admitted the resident on [DATE] with diagnoses including wedge compression fracture of first lumbar vertebrae.Review of the facility document titled Resident Legal Document Checklist, dated [DATE], and signed by R22's spouse, revealed no indication R22 had a Power of Attorney, Health Care Surrogate, Guardian, Living Will, Advance Directive, or other. The box to check all that apply was blank. Therefore, the document was incomplete.Review of R22's Kentucky Medical Orders for Scope of Treatment (MOST) form, updated [DATE], signed on [DATE], revealed any section not completed did not invalidate the form and implied full treatment for that section. Further review of R22's MOST form revealed section A indicated R22 as a Do Not Resuscitate (DNR). However, sections B, Medical interventions; section C, Artificially Administered Fluids and Nutrition; and section D, Antibiotics, had not been completed and were blank. Review of R22's medical record revealed no documented evidence of an advance directive.Review of R22's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three out of 15, indicating severe cognitive impairment. During a telephone interview with R22's spouse on [DATE] at 2:54 PM, he stated R22 did not have a living will or an advance directive. He stated he did not recall being asked nor was he provided with information about a living will or an advance directive.3. Review of R45's Face Sheet, located in the EMR, revealed the facility admitted the resident on [DATE], with diagnoses including myocardial infarction.Review of R45's Kentucky Medical Orders for Scope of Treatment (MOST) form, dated [DATE], revealed any section not completed did not invalidate the form and implied full treatment for that section. Further review of R45's MOST form revealed section A indicated R45 as a Do Not Resuscitate (DNR). Section B indicated limited additional intervention and comfort measures checked with error and initials KC. Section C indicated determine use or limitation of antibiotics, and section D indicated IV fluids for a defined trial period and no feeding tube. However, section E, Patient<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Preferences, had not been completed and was blank.Review of the facility document titled Resident Legal Document Checklist dated [DATE], and signed by R45, revealed no indication the resident had a Power of Attorney, Health Care Proxy, Health Care Surrogate, Guardian, Living Will, Advance Directive or other. The box to check all that apply was blank. Therefore, the document was incomplete. Review of R45's medical record revealed no documented evidence of an advance directive.Review of R45's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a 15 out of 15, indicating intact cognition. In an interview with R45, on [DATE] at 2:30 PM, she stated she did not recall being asked about nor provided with information about a living will or an advance directive.4. Review of R63's Face Sheet, located in the EMR, revealed the facility admitted the resident on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, and psychotic disturbance. Review of R63's Baseline Care Plan, dated [DATE], page six (6), revealed a question, Does Resident have an Advance Directive, and it was answered, No.Review of R63's Kentucky Medical Orders for Scope of Treatment (MOST) form, undated, revealed Cardiopulmonary resuscitation (CPR) was indicated with limited additional interventions. Additional review revealed section C, Artificially Administered Fluids and Nutrition; and section D, Antibiotics, had not been completed and were blank. Additional orders on this form included: full code, Do Not Intubate (DNI). Review of the facility document titled Resident Legal Document Checklist, dated [DATE], and signed by R63's resident representative on [DATE], revealed the resident had a Power of Attorney and a Living Will. However, these documents were not located in the medical record, nor were they submitted by the facility for review.5. Review of R110?s Face Sheet located in the EMR, revealed the facility admitted the resident on [DATE] with diagnoses including Alzheimer's Disease late onset, type 2 diabetes mellitus without complications, and major depressive disorder. Review of R110's Kentucky Medical Orders for Scope of Treatment (MOST) form, dated [DATE], revealed the form was voluntary and could be voided at any time. Any section not completed did not invalidate the form and implied full treatment for that section. Further review of R110's MOST form revealed section A indicated Do Not Attempt Resuscitation and Section B indicated Comfort Measures. However, sections C, Antibiotics; D, Medically Administered Fluids and Nutrition; and E, Patient Preferences, had not been completed and was blank. Review of R110's facility document titled Advance Directives/Informed Consent, dated [DATE] and signed by R110's resident representative, revealed the resident was Do Not Resuscitate. Additional review revealed Designation of Health Care Surrogate was marked, but the date was left blank. 6. Review of R123's Face Sheet, located in the EMR, revealed the facility admitted the resident on [DATE] with diagnoses including urinary tract infection, type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD).Review of the facility document titled Resident Legal Document Checklist, dated [DATE], and signed by R123 on [DATE], revealed no indication R123 had a Power of Attorney, Health Care Surrogate, Guardian, Living Will, Advanced Directive, or other. The box to check all that apply was blank. Therefore, the document was incomplete.Review of R123s Kentucky Medical Orders for Scope of Treatment (MOST) form signed [DATE], revealed Cardiopulmonary resuscitation (CPR) was to be attempted with full treatment.Review of R123's Baseline Care Plan, dated [DATE], revealed a question, Does Resident have an Advanced Directive, and it was answered, Yes. The next question stated, Do you wish to formulate an advanced directive? The answer was also Yes. However, there was no documented evidence of an advance directive in the medical record.During an interview on [DATE] at 9:43 AM, the Regional Nurse Consultant (RNC) stated the facility used the MOST form as the advance directive.During an interview with the Admissions Coordinator, on [DATE] at 11:09 AM, with the Administrator present, she stated she completed the admission documentation for residents. She stated she asked residents or resident representatives if they had an advance directive, a living will or a durable power of attorney (DPOA) during the admission process. She further stated she did not check the box on the form on the admission agreement called resident legal document checklist<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | unless they had the documents and she received and copied them. Additionally, the Admissions Coordinator stated if residents or representatives asked questions, she provided verbal information. However, she stated she did not give residents/resident representatives written information related to advance directives. When questioned if the facility recognized the KY Medical Orders for Scope of Treatment (MOST) form as an advance directive, she stated she did not know.During an interview with the Social Services Director (SSD), on [DATE] at 11:24 AM, she stated she and the admitting nurse talked to the residents about a living will and Durable Power of Attorney upon the resident's admission. She further stated she and the admitting nurse talked about DNR (Do Not Resuscitate) and code status, and the nurse explained code status in detail. She stated resources were offered including living will paperwork, and how to obtain guardianship. She further stated she tried to obtain and provide to every resident and representative whatever resources needed. Further, if the resident or representative asked for information, she gave it to them. The SSD stated the facility did not use the MOST form as their advance directive. Additionally, the SSD stated advance directives were reviewed during care plan meetings.During an interview with the Director of Nursing (DON), on [DATE] at 11:48 AM, she stated the facility used the MOST form when discussing a resident's wishes, but the MOST form was not considered an advance directive. She stated the nurse, and SSD spoke with residents and their representatives to discuss their wishes during the admission process. The DON further stated advance directives were discussed during conference meetings. During an interview with the Administrator, on [DATE] at 3:53 PM, he stated advance directives were discussed with all residents and additional information was provided if requested. The Administrator stated the MOST form was not a legally binding document and the living will would be followed. He stated advance directives were discussed during care conferences to see if any changes needed to be made. He further stated if a resident or representative requested changes then a new Most form would be completed. He stated the MOST form could be used for years if no changes were made. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure that a resident has the right to a dignified existence for 1 of 29 sampled residents reviewed for dignity/resident rights. Observation of Resident (R)27 during mealtime, revealed a staff member was standing at the bedside feeding the resident.The findings include:Review of the facility policy titled, Assistance with Meals, revised 05/13/2024, revealed residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. Additionally, it stated, Employees who provide resident assistance with meals will be trained and shall demonstrate competency in providing meal assistance.Review of the facility policy titled, Resident Rights, revised 01/31/2025, revealed, All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility. It further stated, The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness, and dignity.Review of R27's Resident Face Sheet revealed the facility admitted the resident on 04/25/2025 with diagnoses that included unspecified dementia, contractures of the left and right hips, and dysphagia.Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/2026 revealed the facility assessed R27 as having a Brief Interview for Mental Status of a 2 out of 15 indicating severe cognitive impairment. Further review revealed the facility assessed the resident as dependent on staff for eating.Review of the Comprehensive Care Plan revealed a focus of Activities of Daily Living (ADL) Function, dated 05/02/2025 and revised 04/09/2026, by the Director of Nursing (DON), which stated R27 was independent with eating after assistance with tray set-up.Observation on 04/07/2026 at 6:43 PM, revealed R27 was sitting up in bed. Certified Nursing Assistant (CNA)1 was standing beside the bed while feeding R27.During interview with CNA1, on 04/07/2026 at 6:54 PM, she stated she usually sat while feeding residents, but there wasn't a chair in R27's room at the time the resident received her tray. She further stated there was usually a chair already in the room for the residents that needed to be fed. During an interview with Unit Manager (UM)1, on 04/07/2026 at 6:55 PM, she stated the staff member feeding R27 should have been sitting down. UM1 then requested CNA1 to get a chair so she could sit at the bedside to feed R27, which CNA1 did upon request.During an interview with the Administrator, on 04/10/2026 at 3:50 PM, he stated staff should not be standing at the bedside feeding a resident unless it had been care planned as a preference. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 sampled residents reviewed for Enhanced Barrier Precautions (EBP). Observation on 04/07/2026, revealed Certified Nursing Assistant (CNA) 6 failed to don the appropriate Personal Protective Equipment (PPE) prior to providing direct care to R44, who was on Enhanced Barrier Precautions (EBP).The findings include:Review of the facility policy titled, Infection Control, revised 01/30/2026, revealed the facility infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Further, the object of the infection control policies and practices were to prevent, detect, investigate, and control infections in the facility to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the public.Review of the facility policy titled, Enhanced Barrier Precautions, dated 03/25/2024, revealed EBP were additional measures to attempt to decrease transmission of Multidrug-Resistant Organisms (MDRO). If a resident was placed on EBP, appropriate signage was placed at the room entrance so that personnel and visitors were aware of the need for and the type of precautions. The signage informed the staff of instructions for use of Personal Protective Equipment (PPE), and/or instructions to see a nurse before entering the room. EBP are indicated for residents who have chronic wounds or indwelling medical devices regardless of MDRO status.Review of R44's Resident Face Sheet, revealed the facility admitted the resident on 02/26/2025 with diagnoses including type 2 diabetes mellitus with foot ulcer, type 2 diabetes mellitus with diabetic neuropathy, and cognitive communication deficit. Review of R44's Annual Minimum Data Set (MDS) assessment with an Assessment Reference date (ARD) of 02/18/2026, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.Review of a Physician's order dated 02/18/2026, revealed an order for Enhanced Barrier Precautions (EBP) related to a wound.Review of R44's Comprehensive Care Plan, dated 03/14/2025 and revised 02/19/2026, revealed a focus problem for Infection Control as resident required EBP related to a wound. Interventions included: attempt to maintain environmental cleanliness, disinfecting high-touch surfaces as applicable; personal protective equipment as indicated; and report any signs and symptoms of infection to the physician.Observation on 04/07/2026 at 7:34 PM, revealed room [ROOM NUMBER] had signage posted indicating bed B was on Enhanced Barrier Precautions (EBP). The signage indicated staff was required to wear gowns and gloves when providing direct care.Further observation upon entering R44's room, on 04/07/2026 at 7:34 PM, revealed CNA6 was on her knees at the bedside, leaning on R44's low bed, and there was a bedpan full of urine on the floor in front of her. CNA6 was not wearing the appropriate PPE. Although she was wearing gloves, she was not wearing a gown as required. CNA6 proceeded to the restroom and emptied the bedpan full of urine into the toilet, rinsed the bedpan and bagged it. She then performed hand hygiene prior to exiting the room.During an interview with CNA6, on 04/07/2026 at 7:36 PM, she was questioned if it was a requirement to wear a gown while providing direct care to R44. CNA6 stated, I don't know. CNA6 was questioned if she had seen signage posted at the door, and she again stated, I don't know.During an interview with R44, on 04/07/2026 at 7:40 PM, she was questioned if staff wore gowns when providing care for her. She stated No, and further stated she did not know why staff would have to wear a gown when providing care for her.During an interview with the Staff Development Coordinator/Infection Preventionist, on 04/10/2026 at 12:08 PM, she stated she expected staff to follow signage on the doorways for any precautions. She further stated CNA6 had a language barrier and probably did not understand what the Surveyor was asking. During additional interview, the Staff<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Development Coordinator/Infection Preventionist stated she educated staff constantly on PPE. She further stated she had educated staff just this week. During an interview with the Director of Nursing (DON), on 04/10/2026 at 11:53 AM, she stated when providing direct care to a resident on EBP, staff should wear the appropriate PPE, which would be a gown and gloves as indicated by signage on the door.During an interview with the Administrator, on 04/10/2026 at 3:50 PM, he stated he expected staff to follow the protocols for EBP, which included wearing gowns and gloves when performing direct care activities. |