

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Morrisons Cove Home		STREET ADDRESS, CITY, STATE, ZIP CODE 429 South Market Street Martinsburg, PA 16662	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident and/or resident representative in advance of the risks and benefits of psychotropic medication (medications that affect the persons mental state, emotions and behavior) use and the treatment alternatives prior to initiating the administration of the medication for two of 30 residents reviewed (Residents 6, 10). Findings Include: The facility's policy regarding the use of psychotropic medications, dated January 27, 2026, indicated that prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medications, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated January 15, 2026, revealed that the resident was cognitively intact, received antianxiety and antidepressant medications (psychotropic medications), and had diagnoses that included dementia. Physician's orders for Resident 6, dated February 5, 2026, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (an antianxiety medication) every 6 hours as needed. There was no documented evidence in Resident 6's clinical record that the resident or resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to starting the Ativan. Interview with the Director of Nursing on February 12, 2026, at 11:53 a.m. confirmed that there was no documented evidence in Resident 6's clinical record that the resident or resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to starting the as needed Ativan. A Quarterly MDS for Resident 10 dated February 1, 2026, revealed that the resident was cognitively impaired, was receiving an antipsychotic, antianxiety and an antidepressant medication, and had diagnoses that included anxiety and depression. Physician's orders for Resident 10 dated May 14, 2025, included an order for the resident to receive 12.5mg Trazodone (an antianxiety medication) twice a day. Physician's orders for Resident 10 dated May 28, 2025, included an order for the resident to receive 25mg trazodone twice a day. There was no documented evidence in Resident 10's clinical record that the resident or resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to starting the Trazodone or increasing the dose of Trazodone. Interview with the Director of Nursing on February 12, 2026, at 11:53 a.m. confirmed that there was no documented evidence in Resident 10's clinical record that the resident or resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to starting the Trazodone or increasing the dose of Trazodone. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that medications and treatments were provided as ordered by the physician for three of 30 residents reviewed (Resident 5, 30, 57). Findings include: The facility's policy for administering medications dated January 27, 2026, indicated that medications and treatments are administered in a safe and accurate manner per physician orders and administered by licensed staff that has completed facility's medication administration training program. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 19, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had a diagnosis of osteomyelitis (infection of the bone and bone marrow). Physician's orders for Resident 5, dated November 19, 2025, included orders for 1 gram of Vancomycin (an antibiotic) to be administered intravenously two times a day for osteomyelitis. Review of Resident 5's Medication Administration Record (MAR) for December 2025 revealed no documented evidence that 1 gram of Vancomycin was administered to Resident 5, December 3 at 8:00 a.m., December 6, at 6:00 a.m., December 13, at 6:00 p.m. and December 23, 2025, at 6:00 a.m. as ordered by the physician. An interview with the Director of Nursing on February 10, 2026, at 3:30 p.m. confirmed that 1 gram of Vancomycin was not administered to Resident 5 on the above mentioned days. A Quarterly MDS assessment for Resident 30, dated December 6, 2025, revealed that the resident was cognitively intact and required assistance from staff for daily care needs. Physician's orders for Resident 30, dated August 30, 2025, included an order for the resident to receive 2 step PPD on admission administer 1 step PPD on admission, read results and document results under immunizations, administer 2nd step PPD 14 days after first step is read, read 2nd step PPD and document under immunizations. A review of Resident 30's MAR for September and October 2025, revealed that a 1 step PPD was administered on September 16 during the day shift and was read on September 18, 2025 during the day shift. There was no documented evidence that a 2nd step PPD was administered 14 days after the first step was read. An interview with the Director of Nursing on February 11, at 1:35 p.m. confirmed that a 2nd step PPD was not administered to Resident 30 and it should have been. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 57, dated October 20, 2025, revealed that the resident was cognitively impaired, was understood and was able to understand others, required partial assistance with daily care needs, and had diagnoses that included heart failure. Physician's orders for Resident 57, dated October 2, 2025, included an order for the resident to have compression pump to bilateral lower extremities (both legs) 60mmHG, 1 time per day, 60 minutes a day. Review of the Treatment Administration Record (TAR) for Resident 57, dated October 2025 through January 2026 revealed that there was no documented evidence that compression pumps were applied on October 4, 2025, October 14, 2025, October 18, 2025, October 27, 2025, November 11, 2025, November 14, 2025, November 21, 2025, November 25, 2025, November 26, 2025, December 23, 2025, January 2, 2026, January 5, 2026, January 7, 2026, and January 13, 2026. Interview with the Director of Nursing on February 12, 2026, at 9:29 a.m. confirmed that there was no documented evidence that Resident 57's compression pumps were applied on the above date and times and there should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for the care and maintenance of intravenous catheters and failed to ensure that intravenous catheters were flushed according to facility policy for one of 30 residents reviewed (Resident 5). Findings include: The facility's policy regarding flushing peripheral catheter (a thin, flexible tube that is inserted into a vein to administer fluids, blood, or medications), dated January 27, 2026, indicated that peripheral intravenous (IV) catheters will be flushed prior to each infusion to assess catheter patency and function, and after each infusion to clear the catheter lumen of medication and to prevent contact between incompatible medications. Staff was to use the push-pause technique to instill the normal saline. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 19, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had a diagnosis of osteomyelitis (infection of the bone and bone marrow). Physician's orders for Resident 5, dated November 19, 2025, included orders for 1 gram of Vancomycin (an antibiotic) to be administered intravenously two times a day for osteomyelitis. Physician's orders for Resident 5, dated November 21, 2025, included orders to place PICC or Midline catheter (a thin, flexible tube that is inserted into an upper arm vein to administer fluids or medications) for blood draws as well as administration of medication. Review of Resident 5's Medication Administration Records (MAR's) for November and December 2025 revealed no documented evidence that Resident 5's midline catheter was flushed before and after the administration of the antibiotic. Interview with the Director of Nursing on February 11, 2026, at 2:11 p.m. confirmed that there was no documented evidence that Resident 5's midline catheter was flushed before and after the administration of the antibiotic. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure communication between a dialysis provider and the facility's nursing staff and failed to have a contract with the Dialysis facility for one of 30 residents reviewed (Resident 9). Findings include: An Annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated November 14, 2025, revealed that the resident was understood and could understand, and had diagnoses that included end-stage renal disease (the last stage of chronic kidney disease, where the kidneys are only functioning at 10 to 15 percent of their normal capacity). The resident's care plan, dated May 23, 2024, revealed that the resident received dialysis on Monday, Wednesday, and Friday. Review of the clinical record for Resident 9 revealed that there was no documented evidence of routine collaboration of care and communication between the long-term care facility and the dialysis center, when the resident received dialysis services, and there was no documented evidence of a contract with US Renal the dialysis facility. Interview with the Director of Nursing on February 11, 2026, at 1:46 p.m. confirmed that there was no documented evidence of communication between the dialysis facility and the facility because the facility does not send any paperwork back, and the facility does not have a contract with the dialysis center. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		