STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515049	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Health and Rehabilitation, LLC	1379 Van Voorhis Rd Morgantown, WV 26505

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49465 Based on record review and staff interview the facility failed to report an allegation of suspected abuse within (2) two hours after discovering the occurrence. This failed practice was found true for (1) of (3) residents reviewed for reportable allegations of abuse, neglect, and misappropriation of property. Resident identifier: #40. Facility Census: 68. Findings Included: a) Resident #40 A review of the facilities reportables, on 05/21/24 at 9:00 AM, revealed that Resident # 40 had a bruise of unknown origin on the posterior upper left arm described as large deep purple bruising according to the skin assessment completed on 04/25/24. The incident was reported on 04/26/24 at 3:45 PM, which was 16.5 hours post incident. A medical record review, on 05/21/24 at 9:15 AM, revealed a nurse's note written on 04/25/24 at 11:15 PM, that reads as follows: Called to room by aide. Large deep purple bruise noted to posterior left upper arm. Denies pain at present. Normal ROM to arm. No warmth or nodules noted to the area. MD, Administrator, and DON notified. Further medical record review revealed the following social services note written on 04/25/24 at 4:00 AM, that reads as follows: I met with the patient due to her reporting that staff had caused her bruising. The patient was not able to give me any information, she was oriented x 1 and thought process was confused for any new information. She scored a 6 on the BIMS. She was not able to give me any information about what had happened. This information was reported to the administrator. During an interview, on 05/21/24 at 11:50 AM, with the Corporate Registered Nurse (CRN), and the Social Worker (SW), when asked by surveyor, If you didn't feel it was abuse why did we have a note saying that Resident # 40 reported that staff had caused the bruising? CRN stated, (SW name), why did you put that note in there. SW did not respond at this time. A further interview, at 11:55 AM on 05/21/24, with the SW she confirmed that suspected abuse allegations should be reported with-in (2) two hours. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities policy, on 05/22/24 at 1:30 PM titled Freedom from Abuse and Neglect Policy revealed that all alleged violations must be reported no later than two (2) hours if the alleged violations involve abuse or serious bodily injury.

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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. 50801 Based on record review, staff interviews, the facility failed to follow the physician's order for antibiotics. Resident #73 did not receive Zyvox as ordered by the attending physician. Resident identifier: #73. Facility census: 68. Findings included: a) Resident #73 A medical record review revealed Resident #73 had a physician order for Zyvox dated 02/14/24. The medication was ordered to be given twice a day. During a confidential interview with a nurse the nurse said when they went to administer the morning dose on 02/14/24 they clicked administered but the medication was not available in the Alixa. The nurse said they needed to strike themedicaiton out and called Alixa to see if the medication was approved or enroute. The nurse said that LPNs or floor nurses are not allowed to approve medications nor do they receive emails to approve medications. On the evening of 02/14/214 the medication was ordered but had not arrived in the facility. The nurse said the medication was on hold due to the cost. The cost had to be approved by the facility. The Director of Nursing approved the medication but it did not arrive until it was time for the morning dose of 02/15/24. By this time the resident had already missed two (2) doses of Zyvox. The medication arrived in the early morning of 02/15/24. After this happened the Director of Nursing said Zyvox was put into the Alixa. On 02/15/24 the resident's son arrived at the facility and questioned whether or not his father had received the medication which was prescribed for a UTI. The resident's son requested his father be sent out of the facility due to him missing two (2) doses of the medicaiton.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50801 Based on record review, staff interviews, the facility failed to provide pharmaceutical services to meet the needs of a resident. Resident #73 did not receive Zyvox as ordered by the attending physician. Resident identifier: #73. Facility census: 68. Findings included: Based on record review, staff interviews, the facility failed to follow the physician's order for antibiotics. Resident #73 did not receive Zyvox as ordered by the attending physician. Resident identifier: #73. Facility census: 68. Findings included: a) Resident #73 A medical record review revealed Resident #73 had a physician order for Zyvox dated 02/14/24. The medication was ordered to be given twice a day. During a confidential interview with a nurse the nurse said when they went to administer the morning dose on 02/14/24 they clicked administered but the medication was not available in the Alixa. The nurse said they needed to strike themedicaiton out and called Alixa to see if the medication was approved or enroute. The nurse said that LPNs or floor nurses are not allowed to approve medications nor do they receive emails to approve medications. On the evening of 02/14/214 the medication was ordered but had not arrived in the facility. The nurse said the medication was on hold due to the cost. The cost had to be approved by the facility. The Director of Nursing approved the medication but it did not arrive until it was time for the morning dose of 02/15/24. By this time the resident had already missed two (2) doses of Zyvox. The medication arrived in the early morning of 02/15/24. After this happened the Director of Nursing said Zyvox was put into the Alixa. On 02/15/24 the resident's son arrived at the facility and questioned whether or not his father had received the medication which was prescribed for a UTI. The resident's son requested his father be sent out of the facility due to him missing two (2) doses of the medicaiton.