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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Heights of Journey	1379 Van Voorhis Rd Morgantown, WV 26505

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to develop and/or implement the care plan regarding a diagnosis for Resident #43, include antipsychotic medications for Resident #80, and the use of adaptive utensils for Resident #5. This was true for three (3) of 31 residents reviewed during the survey process. Resident Identifiers: #43, #80, and #5. Facility Census: 72.Findings Include: a) Resident #43 On 09/08/25 at 11:30 AM, a record review was completed for Resident #43. The review found all diagnoses were not included in the care plan. The diagnosis, which was added to the medical record on 09/26/24, that was not included was obstructive and reflux uropathy. On 09/08/25 at 2:13 PM, Corporate Nurse (CN) #300 confirmed the care plan had not been developed regarding the diagnosis obstructive and reflux uropathy. b) Residnet #80 On 09/09/25 at 10:00 AM, a record review was completed for Resident #80. The review found the care plan was not developed completely under the focus area of antidepressant and antipsychotic medications. The care plan focus areas were listed as follows: --The residnet uses antidepressant medication (SPECIFY medications r/t (related to) depression. --The resident uses psychotropic medications (antipsychotics) r/t behavior management. On 09/09/25 at approximately 11:45 AM, the Corporate Nurse #300 confirmed the care plan had not been developed completely, due to blank areas. c) Resident #5 On 09/03/25 a record review was completed for Resident #5 and revealed resident required adaptive utensils/not care planned. Review of document titled Current Order Summary revealed resident is ordered to use right curved silverware for all meals on 09/19/24. Review of Resident #5's care plan on 09/03/25 revealed no mention of any adaptive silverware needed for meals. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/04/25 at approximately 4:00 pm with Corporate Nurse #300 who acknowledged that resident's order for curved silverware was not discussed in her care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to revise a care plan regarding actual falls for Resident #12, amount of assistance needed for showering for Resident #20, and physical and verbal aggression for Resident #46. This was true for three (3) of 31 residents reviewed during the survey process. Resident Identifiers: #12, #20, and #46. Facility Census: 72.Findings Include: a) Resident #12 On 09/09/25 at approximately 1:00 PM, a record review was completed for Resident #12. The review found the care plan focus area was listed as fall risk r/t (related to) weakness, balance problem. The review, also, found the resident had two (2) actual falls on 04/24/25 and 06/21/25. On 09/09/25 at 2:15 PM, the Corporate Nurse #300 confirmed the care plan was not revised to include the two (2) actual falls. b) Resident #20 On 09/10/25 at 9:00 AM, a record review was completed for Resident #20. The care plan was reviewed with the focus area of Requires assistance with Activities of Daily Living debility. The interventions included Shower/Bathe: set up/clean up. However, in reviewing the documentation under tasks tab for Bathing (Prefers: Monday and Thursday day shift.) On five (5) occasions, documented from 08/01/25 through 08/31/25, the assistance noted physical help in part of bathing activity; and, on two (2) occasions the assistance was noted was total dependence. On 09/10/25 at approximately 11:30 AM, the Corporate Nurse #300 confirmed the care plan intervention did not match the actual assistance needed for bathing. c) Resident #46 Record review and interview on 09/09/25 at approximately 1:30 PM revealed that Resident #46 had hit Resident #74 with a closed fist, in the dining room, on 08/22/25. Records reveal that the residents were separated. Resident #74 was assessed and found to be free of injury, and Resident #46 was placed under one-on-one supervision. A review of Resident #46's Care Plan on 09/09/25 at 1:30 PM revealed no updates or implementations to address the resident's abusive behavior. The Care Plan revealed the following documentation: A review of the resident's care plan revealed the following focus areas: Occasionally grabbing at staff, making suggestive gestures toward female residents, becoming easily annoyed and aggressive with staff, During an interview with the [NAME] President of Clinical Services (VPCS) #300, on 09/09/25 at 2:45 PM, she confirmed that the care plan had not been updated, and that no protocols had been put in place to address Resident #46's actions toward other residents.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview, and record review, the facility failed to promote residents' right to self-determination and choices in the areas of medication administration and discharge planning. Resident Identifier: #52. Facility Census: 72.Findings Includea) Resident #52During an interview on 09/03/2025 at approximately 10:55 AM, the resident stated that on 08/30/25, she and her roommate had to wait until around 11:45 PM for their medications. Resident stated that she requests her prescribed PRN Oxycodone and Tizanidine when her arm spasms become uncontrollable. The resident further stated that she usually requests these medications before she goes to sleep.On 08/29/25 at approximately 9:30 PM, the resident stated that she asked a Nursing Aide (NA) to notify the nurse that she wanted her medications. The resident could not remember who the NA was. The resident reported that the nursing assistant (NA) returned and informed her that the nurse could not be located on the floor. The NA promised to notify the nurse about the resident's need for medication as soon as the nurse was available. The resident stated that she received her medication at 11:45 PM, after which she went to sleep. Additionally, the resident mentioned that on 08/24/25, she requested her medication at approximately 9:30 PM but did not receive them until 10:30 PM.Record review on 09/04/24 at 11:41 AM revealed that the resident is prescribed the following medications:Oxycodone HCl Oral Tablet 10 MG - Give 10 mg by mouth every 6 hours as needed for pain control-Start Date-05/29/25 at 4:15 PM.Tizanidine HCl 2 MG Tablet - Give 1 tablet by mouth every 12 hours as needed for tremors-Start Date- 05/30/25 at 2:30 PMFurther record review of the Medication Administration Record (MAR) confirmed that the medications were administered on 08/24/25 at 10:30 PM, and on 08/30/25 at 11:45 PM.On 09/0925, at approximately 1:55 PM, an interview was conducted with Resident #52, accompanied by the [NAME] President of Clinical Services (VPCS) #300. During the interview, the resident expressed that she did not receive her medication when she needed them. She further indicated that after requesting her medications, it took almost one and a half hours for the nurse to return with them.VPCS #300 asked the resident about her preferred time to receive her medications. The resident explained that she needed her medications when the spasm in her arm became difficult to manage, usually around 9:00 PM. In response, VPCS #300 stated that she would instruct the nurses to offer the medications to the resident at around 8:00 PM each day. The resident could then decide whether to take the medications at that time or later. The resident voiced her agreement with the arrangement.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to notify the representative / emergency family member of medical changes. This was true for one (1) of three (3) residents reviewed for the care area of hospitalization during the annual long-term care survey process. Resident identifier: #60. Facility census: 72. Findings included:a) Resident #60A record review, completed on 09/04/25 at 12:40 PM, revealed Resident #60 had capacity to make his own medical decisions. It also revealed Resident #60 was transferred to the hospital on [DATE]. Resident #60's daughter was listed as Emergency Contact on the profile page of resident's electronic medical record. Section E1, of the 06/25/25 eINTERACT Transfer Form, entitled Key Contacts displayed the wording null. A progress note, dated 06/25/25 at 10:04 PM, stated, . pt (patient) has capacity and is aware of situation.There was no evidence that Resident #60's emergency contact was notified of the acute transfer to the hospital. During an interview, on 09/04/2025 at 1:13 PM, the Director of Nursing (DON) indicated the facility had not notified Resident #60's designated representative/family member of the transfer to the hospital.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to perform a thorough investigation after an instance of resident-to-resident abuse. This was a random opportunity for discovery. Resident Identifiers: Resident #46. Facility Census: 72.Findings Include:a) Resident #46On September 9, 2025, during an interview conducted at approximately 1:08 PM, Resident #5 expressed concern about the behavior of Resident #46 towards other residents in the dining room. Resident #5 reported that Resident #46, who is known for his temper, threw a cup at another male resident, narrowly missing him. Additionally, about a month ago, Resident #46 became irritated with Resident #74 when she approached and began touching items on his table. In that instance, Resident #46 reportedly hit Resident #74 and told her, Go sit down! Sit down, or I will put you down, and you will be down for the rest of the day. Resident #5 also mentioned that Resident #46 called Resident #74 a bitch. It's worth noting that staff members were present during both incidents.Record review revealed that Resident #46 has a Brief Interview for Mental Status (BIMS) score of 15. When questioned about the incident on 09/08/25 at 1:20 PM, while the resident was coloring a picture mounted on the wall, the resident ignored the question. Resident #74 had a BIMS score of 00.A record request on 09/09/25 revealed that the incident between Resident #46 and Resident #74, which occurred on 08/22/25 at approximately 5:45 PM, had been reported to the Office of Health Facility Licensure and Certification (OHFLAC) and Adult Protective Services (APS) at approximately 6:00 PM on 08/22/25.Facility records also revealed that the five-day follow-up report had been submitted to OHFLAC on 08/25/25 at 8:32 PM.Report submitted to OHFLAC at 08/25/25 at 8:32 PM.A review of the facility's investigative records revealed the following statements from facility staff:A statement by Nursing Assistant (NA) #32 on 08/25/25 stated: Before dinner was served, the residents were gathered in the dining room, waiting for supper services. Resident #74 was ambulating throughout the dining room, adjusting tablecloths when she approached Resident #46's table, he told her to get away from his table, and she replied No, we then were heading toward the table to intervene (NA #51 and I). Before we got there , he had struck Resident #74 in the arm shoulder area with a closed fist. (I was sitting near the kitchen; NA #51 was passing drinks). Resident #74 then pointed at Resident #46 and said something, but I could not hear her. Resident #46 continued to yell to get that stupid bitch away from me. NA #51 escorted Resident #74 out of the dining room to the North nurses station. Resident #46 refused to leave separate from the dining room. He calmed down and ate dinner. We kept him under one-on-one supervision. Resident #74 then returned to the dining room after being assessed by the nurse and ate her dinner. No change in mood or behavior noted. Another verbal statement by Licensed Practical Nurse (LPN) #70 stated:I was [Resident #74's] nurse. [Resident #74] did not act any differently than usual. Resident went to dining room for dinner and showed no agitation at that time. [Resident #74] after the event was fine. She showed no signs of being upset.Interviews were conducted with Residents #52, #59 and #62 on 09/09/25 at approximately 11:44 AM. Residents #59 and #62 had no knowledge of the incident because they ate their meals in their rooms. Resident #52 stated that her memory was bad, and she was unable to remember any incident.Record review on 09/09/25 at 1:20 PM revealed that the facility investigation consisted of asking the residents the following two questions: 1. Do you feel safe here?2. Has any resident hit you? The facility failed to conduct a thorough investigation of the incident by not interviewing any residents regarding the incident that occurred in the dining room on 08/22/25.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and staff interview, the facility failed to provide evidence the resident or the resident's representative was provided a written Notice of Transfer/Discharge when a resident was discharged from the facility. This was true for two (2) of three (3) residents reviewed for discharges. Resident identifiers: #60 and #82. Facility census: 72.Findings included: a) Resident #60A medical record review, completed on 09/09/25 at 12:26 PM, revealed Resident #60 was discharged from the facility on 06/25/25. The record did not reflect the resident or resident's representative was provided with a written Notice of Transfer / Discharge indicating the reason for transfer, the effective date of transfer, the location to which the resident was being transferred and a statement of the resident's appeal rights.During an interview on 09/09/25 at 3:00 PM, the Director of Nursing (DON) acknowledged the facility was unable to provide evidence that a written Notice of Transfer / Discharge had been provided. b) Resident #82A medical record review, completed on 09/09/25 at 2:55 PM, revealed Resident #82 was discharged from the facility on 06/15/25. The record did not reflect the resident or resident's representative was provided with a written Notice of Transfer / Discharge indicating the reason for transfer, the effective date of transfer, the location to which the resident was being transferred and a statement of the resident's appeal rights.During an interview on 09/09/25 at 3:01 PM, the DON acknowledged the facility was unable to provide evidence that a written Notice of Transfer / Discharge had been provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the Minimum Data Set (MDS) assessment included all diagnoses for Resident #43. This is true for one (1) of five (5) residents under the care area of unnecessary medications. Resident Identifier: #43. Facility Census: 72. Findings Include: a) Resident #43 On 09/08/25 at 12:30 PM, a record review was completed for Resident #43. The review found all diagnoses were not included on the MDS quarterly dated 07/28/25 section I. After reviewing all diagnoses, the diagnosis, which was added to the medical record on 09/26/24, was obstructive and reflux uropathy. On 09/08/25 at 2:15 PM, the Corporate Nurse #300 confirmed the diagnosis of obstructive and reflux uropathy was not included in the MDS dated [DATE].

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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 the facility failed to submit a new Pre-admission Screening (PAS) when a diagnosis was not captured upon admission, This is true for one (1) of two (2) residents reviewed for PAS. Resident #57, Facility Census 72.Findings included: a) Resident #57 On 09/04/25 a review of Resident # 57's most recently completed Pre-admission Screening (PAS) submitted on 07/24/23 revealed the following: Question number 30. Current Diagnosis marked a. None Question 40. Major Mental Illness or suspected MI marked I. none Question 47. The individual has a primary diagnosis of: options Dementia, Related Neurocognitive Disorder Including Alzheimer's Disease, marked N/A. Review of Resident #57's current medical record document titled Diagnosis Report listed the resident's diagnosis to include the following:Alzheimer's Disease, Unspecified(G30.9), Primary Diagnosis, onset 03/25/24Schizophrenia, unspecified (F20.9), onset 7/27/23 Major Depressive Disorder, Single Episode, Mild (F32.0) , onset 07/22/24Interview with Social Worker at approximately 2:30 PM who reported PAS had been redone on this date and was awaiting the doctor's signature at this time to be submitted

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and staff interview, the facility failed to assist with activities of daily living (ADLs) for a dependent resident. This was true for one (1) of one (1) residents reviewed under the care area of activities of daily living. Resident identifier: #20 Facility Census: 72.Findings Include: a) Resident #20 On 09/03/25 at 3:24 PM, the resident was observed in his room appearing unkempt with greasy hair. On 09/10/2025 at 9:00 AM, a record review was completed for Resident #20. The review, included showers and bed baths, between 08/01/25 through 09/04/25. The review found the resident did not have a shower or bed bath between 08/11/25 through 08/18/25, which was seven (7) days; 08/21/25 through 08/27/25, which was six days, and from 08/28/25 through 09/04/25, which is seven (7) days. No bed baths were noted during any of these time frames, as well as no refusals. The resident was, also, noted to need physical assistance or dependent for showers during this time frame. On 09/10/25 at 11:30 AM, the Corporate Nurse #300 was notified of the ADLs which were not provided. On 09/10/25 at approximately 1:30 PM, the Corporate Nurse #300 stated, I checked with the aide .she forgot to document because she was busy. On 09/10/25 at 1:40 PM, the Corporate Nurse #300 did acknowledge there was no documentation in the record to show any other showers or bed baths were given to Resident #20.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review and staff interview, the facility failed to post the daily staff posting in a readily accessible area for residents and/or visitors to view and failed to provide an accurate daily posting on six (6) of eight (8) days sampled. Facility Census: 72. Findings Include: a) Staff Posting Accessibility On 09/09/25 at 1:45 PM, a tour of the facility was completed. There was no daily staff posting at or near the north side nurses' station. On 09/09/25 at 2:00 PM, a tour of the facility was taken. The south side of the facility was noted with the daily staff posting on a glass panel behind the receptionist's desk near the administrative offices. This was not readily accessible to the residents and/or the visitors. On 09/09/25 at 2:05 PM, an interview was held with the [NAME] President of Operations (VPO) #19. VPO #19 did confirm the daily staff posting was not readily accessible at the South nurses' station. VPO #19 stated, We have had problems with residents taking it if it is placed at the desk. The [NAME] President of Operations #19 stated, We will try and put it in a frame at the receptionist's desk. b) Inaccurate Daily Staff Posting On 09/10/25 at 10:00 AM, a review of eight (8) daily staff postings were reviewed. The following six (6) daily staff postings were not accurate: --01/04/25 missing evening shift census--02/14/25 missing evening shift census--03/09/25 missing evening shift census--04/12/25 missing evening shift census--06/28/25 missing evening shift census--07/03/25 missing day and evening shift census On 09/10/25 at approximately 1:30 PM, an interview was held with Payroll Benefits Coordinator #6 regarding the daily staff posting being not accurate. The Payroll Benefits Coordinator stated, I'm not sure why it wasn't filled out completely.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview, and record review, the facility failed to ensure medically related socail services were provided to one (1) resident. The facility failed to notify the resident that the Notice of Medicare Non-Coverage issued to him was deemed invalid, that Medicare would continue to pay for services, and that no specific date had been set for discharge. This was true for one (1) of thirty-one (31) residents surveyed. Resident Identifier: #62. Facility Census: 72.b) Resident #62During an interview with Resident #62 on 09/03/25 at approximately 11:35 AM Resident #62 stated that he was scheduled to be discharged from the facility on 09/04/25 because he had received a Notice of Medicare Non-Coverage (NOMNC). Resident #62 was concerned about the clutter in his house. He states that he would be unable to wheel his walker or wheelchair through the house because there is no clear path. Resident also stated that he had spoken to the Social Worker (SW) on 09/02/25 and asked her about his appeal. He stated that he had not received any notification that his appeal had been successful.During interviews with the Physical Therapist (PT) #53 on 09/04/25 at 11:39 AM she stated that the resident had reached his potential. She stated that resident can walk approximately 400 ft with his walker. He is also able to transfer safely. During an interview with Occupational Therapist (OT) #39 on 09/04/25 at approximately 11:59 AM, she stated that she had worked with the resident on medication management. She noted that the resident is not interested in managing his medications by himself. Currently, the resident's wife, who resides with him at the facility, manages his medications. OT #39 also stated that she was working with the resident on some higher-level tasks, such as preparing meals for himself and showering. OT #39 indicated that the resident can perform these tasks but expresses concern about safely ambulating around his house.During an interview with the SW on 09/03/25 at approximately 12:44 PM, the SW stated that the resident had appealed and won the appeal and would remain at the facility till 09/19/25. During another interview with the resident on 09/03/25 at approximately 1:10 PM, the resident stated that he had not been informed that his appeal had been successful. The SW was notified that on 09/04/25 at approximately 1:20 AM, Resident #62 had no knowledge that his appeal had been successful, and he still believed that he had to leave on 09/04/25. The SW stated that she would go over and notify him.Record review on 09/04/25 at approximately 1:39 AM revealed that the resident had received a NOMNC from the facility on 08/22/25, which stated that his Medicare Coverage of his Current Skilled Nursing Facility Services would end on 08/28/25.

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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Heights of Journey	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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received necessary dental services, including routine dental care. Additionally, the facility failed to provide the assistance needed or requested by residents to obtain these services. This finding applied to one (1) of the thirty-one (31) residents surveyed Resident Identifier: #68. Facility Census:72.Findings include a) Resident #68 During a brief interview on 09/03/25 at approximately 3:04 PM it was observed that Resident #68's teeth were severely discolored and decayed. During an interview with Resident #68's Case Manager at Adult Protective Services (APS) on 09/04/25 at approximately 10:45 AM, she stated the following: I signed consent for dental surgery for the resident on 12/26/24. My coworker signed consent for Medicaid 360 services in November of 2024. There are no other mentions of dental issues in the system. Below is a general description the oral surgeon provided:Full Mouth Debridement Silver Diamine Fluoride Treatment Ext.Erupt Tth/Expsd Root-Elev &/Or Forceps Remvl.Record review revealed that resident was seen by 360 Care on 01/09/25:Physician's note stated: [Typed as Written]Emergency exam. Patient presents for a limited exam with root tips still present. Probable cause - broken teeth. Location-upper. Area has been a problem a year plus ongoing. The following course of treatment was recommended - Extraction needed but patient declined treatment today and did not want to remove any teeth at this time. Several attempts made with her today and unsuccessful.Record review on 09/04/25 at 11:22 AM revealed that the resident had been admitted to the facility on [DATE] and had not been referred for a dental evaluation till December 2024.The facility had scheduled another evaluation for 04/03/25, but the resident refused to be seen by the dentist.During an interview with the [NAME] President of Clinical Services (VPCS) #300 on 09/09/25 at 10:45 AM, she confirmed that the resident had not been referred for services in a timely manner after admission to the facility.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation and record review the facility failed to provide resident with the appropriate assistive devices to maintain or improve their ability to eat or drink independently. This was true for one (1) of thirty-one (31) residents sampled. Resident #5. Facility Census: 72.Findings Includea) Resident #5On 09/03/25, at approximately 12:20 PM, during a dining observation, Resident #5 was seen in the dining room struggling with her utensils. After unwrapping them, she awkwardly attempted to use the fork to pick up her food.When asked why she was having trouble with her utensils, Resident #5 explained that she was supposed to have right-angled adaptive equipment for feeding herself. She added, But today, they gave me these!A review of the resident's tray ticket indicated specific instructions for right-angled utensils.During an interview with Dietary Manager (DM) #18, she confirmed that Resident #5 required right-angled adaptive equipment. DM #18 stated that she would immediately provide the resident with a set of adaptive utensils

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to maintain an accurate medical record for two (2) of 31 sampled residents reviewed in the Long-Term Care Survey process. The facility failed to obtain a resident's signature on a Physician Orders for Scope of Treatment (POST) form and the facility failed to document an accurate weight for a resident. Resident identifiers: #60 and #20. Facility census: 72. Findings included: a) Resident #60 An electronic medical record review, completed on 09/03/25 at 9:45 PM, identified Resident #60 had a Physician Orders for Scope of Treatment (POST) form on file. The attending physician signed the form on 06/16/25. However, Resident #60 had never signed the form. The 2021 POST Form Guidance instructs the signature section provides a declaration on behalf of the patient related to their voluntary participation in the completion of the POST form and agreement with the orders on the form. The patient must sign and date this section for the form to be legally valid. During an interview on 09/04/25 at 11:15 AM, LPN #103 acknowledged the facility had failed to obtain a written signature from Resident #60 stating he was unable to sign. LPN #103 then acknowledged that the professional standard of practice would have been to have two (2) staff members sign witnessing Resident #60's agreement to the form. b) Resident #20 On 09/08/25 at 11:30 AM, a record review was completed for Resident #20. The review found a discrepancy in the resident's weight documentation. On 08/08/25 at 12:21 PM, the recorded weight was 163.0 pounds. On 09/01/25 at 1:35 AM, the recorded weight was 222.8 pounds. This is a weight gain of 59.8 pounds in 24 days. The documentation did include a warning noting a weight gain. However, no reweight was completed at this time. On 09/08/25 at 12:15 pm, the Corporate Nurse #300 was asked, Do you think this weight obtained is accurate? On 09/08/25 at 12:44 PM, the Corporate Nurse #300 stated, We reweighed the resident, the weight is 170.1 pounds. I'm not sure what happened, but it was documented incorrectly.