| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515058 | A. Building<br>B. Wing | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Morgantown Healthcare Center | 30 Mon General Drive<br>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 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.<br><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 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on interview and record review, the facility failed to provide residents with a written notice of the room change, including the reason for the change. Additionally, the facility failed to provide the resident with the opportunity to visit the new room prior to relocation. Resident Identifiers: #69 and #70. Facility Census: 118. Findings Include a) Resident #69During an interview on 10/14/25, at approximately 12:45 PM, Resident #69 stated that she had been living in her current room since 04/0/25. She mentioned that on 07/31/25, Administrator #160 informed her that she would need to pay $327.00 a month to remain in her room. Resident #69 expressed that she was unable to afford the additional charge. She conveyed her distress over the situation and informed her daughters about Administrator #160's comments. Resident #69 then motioned to her daughter, who was present in the room, and indicated that she could explain what had happened. Resident's daughter stated that she had spoken with Administrator #160 regarding her mother's stay at the facility. She noted that her mother had been in the same room for over two years, during which time they had never been required to pay an additional charge. The daughter stated that Administrator #160 had responded, That is the way it is working now! Due to her inability to resolve the issue, the resident's daughter contacted the Regional Director of Operations (RDO) #162. He scheduled an appointment to meet her at the facility on 08/04/25. However, the resident's daughter reported that RDO #162 did not attend the meeting. Instead, another corporate representative arrived and spoke with her, but she described this person as unhelpful. The resident's daughter mentioned that she had agreed to pay the necessary fees to ensure her mother could stay in her room while she worked on resolving the issue. She also reported that she attempted to contact RDO #162 on his cell phone on 08/04/25 but did not receive a response. The resident's daughter went on to state that since she had been unable to resolve the matter, she submitted a complaint to Communicare on 08/04/25. She also stated that she spoke to the Ombudsman on 08/04/25. Resident #69 reported that on 08/13/25, while heading to activities, she was approached by SW and informed that she was being moved to a semi-private room for non-payment. She mentioned that she had not received any invoices from the facility and expressed her distress over not having the funds to cover the required balance. Resident #69 explained that she relies on her daughters for financial support and that, after her last meeting with the facility representative, her daughters had agreed to pay the additional charges. She assumed that the matter had been resolved. The resident's daughter mentioned that her other sister had entered the facility on 08/13/2525, and asked Administrator #160 why they had not been contacted. Administrator #160 responded by saying, We cannot notify you of every little detail! The resident's daughter also stated that Administrator #160 later entered her mother's room and told her sister, You are not representing yourself very well; you are being too emotional! The resident's daughter reported that she made an online payment for the extra charge on 08/13/25, and attempted to contact RDO #162 but did not receive a response. She also mentioned that she spoke with the Ombudsman on the same day, who promised to return her call; however, she has not heard back from the Ombudsman since then. Additionally, the resident's daughter indicated that she has not received any communication from the facility regarding the complaint she submitted. During an interview with SW on 10/14/25, at approximately 2:22 PM, SW confirmed that the facility had not provided Resident #69 with advance written notification regarding her non-payment. She also confirmed that the resident had not received an invoice for the additional charges associated with her private room. Furthermore, SW stated that on 08/13/25, Administrator #160 had instructed her to inform Resident #69 that she would be moved to a semi-private room immediately due to non-payment.During an interview with [NAME] Office Manager (BOM) #62 on 10/14/25, at approximately 3:11 PM, BOM #62 stated that the facility had previously decided not to enforce an additional charge for private rooms. However, she mentioned that Administrator #160 had made the decision to selectively start charging residents for their private rooms. When asked if the residents had been informed about the additional cost to remain in their private rooms, she indicated that selected residents had been verbally notified.On 10/14/25 at approximately 3:30 PM, BOM #62 provided a list of residents who were being billed for their private pay rooms. A review of the list revealed the following information:There were a total of thirty-two (32) residents in private rooms. Ten (10) of these residents were Medicaid residents who were being charged an extra fee for a private room.Two (2) of these residents were private pay.Twenty (20) of these residents were Medicaid residents, and they had not been billed for their private rooms.During the interview on 10/14/25 at 3:11 PM, BOM #62 was questioned about the facility's policy for billing these residents. BOM #62 stated that during the previous |