STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515058	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Healthcare Center	30 Mon General Drive Morgantown, WV 26505

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review, staff interview, the facility failed to take actions to thoroughly investigate an alleged violation related to physical abuse. Resident identifier #76. Facility census: 116. Findings included: a) Resident #76 A record review found an allegation from 06/06/24 where a staff member allegedly fingerpainted with feces on Resident #76. A reportable was completed with the following details: -On 06/06/24 an anonymous call was placed to the corporate hotline. The caller alleged that a Nurse Aide (NA) defecated on a male resident and drew pictures on the resident with her feces. The anonymous caller may have been a disgruntled employee who believed that this NA got her terminated. During an interview on 04/30/25 at approximately 10:00 AM with the Assistant Administrator, he verified that he helped complete some of the resident interviews after the allegation was reported on 06/06/25. He stated that he was unsure if the allegation had occurred. He continued to state that at the time he believed that it was a disgruntled employee. A review of an investigation revealed that the issue was reported to Nurse Aide Registry on 06/06/24, the NA no longer works at the facility, but a situation did occur just not as reported by caller. Continued review of the reportable found no witness statements from the employees that may have knowledge of the allegation. During the interview on 05/01/25 at 9:30 AM the Administrator verified that there was no documentation or statements from all staff working at the time or that may have knowledge of the allegation.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 staff interview and record review, the facility failed to update Resident #107's care plan for discontinuation of an anticoagulant and to clarify Resident #264's care plan for level of assistance needed for activities of daily living. These failed practices were a random opportunity for discovery and had the potential to affect a limited number of residents. Resident Identifiers: #107 and #264. Census: 116. Findings included: a) Resident #107 On 04/29/25 at 03:56 PM, Resident #107 had an order for Lovenox Injection which was discontinued on 02/17/25. The resident's current care plan (revised 02/18/25) stated, Resident is at risk for abnormal bleeding or hemorrhage due to anticoagulant/antiplatelet use for prophylaxis. Resident will be free from abnormal bleeding / hemorrhaging through review date. Educate resident / resident representative on benefits and potential risks of anticoagulant drug use. Encourage resident to use electric razor when shaving, soft bristled toothbrush. If excessive bleeding / hemorrhage occurs, provide emergency care. Monitor for s/sx [signs and symptoms] of bleeding (i.e. bruising, petechiae, epistaxis, GI bleeding, hematuria, nose bleeds, tarry/black stools bleeding gums). Notify medical provider, resident / resident representative, as needed. Provide anticoagulant//antiplatelet medication per medical providers order. Monitor for effectiveness, and side effects (bleeding, embolism). Report abnormal findings to medical provider, resident / resident representative. The Administrator confirmed there was not a current order on 04/30/25 at 12:05 PM and stated, It's not there .okay. b) Resident #264 On 05/06/25 at 10:15 AM, Resident #264's care plan stated: Helper does ALL of the effort or 2 or more helpers assist. The state surveyor interviewed Minimum Data Set (MDS) Nurse #44 and MDS Nurse #120. Information for the care plan is based on the usual performance during the look back dates per report. The MDS Nurse's stated Activities of Daily Living may fluctuate and Resident #254's care may change if patient is resistive to care. If cooperative - maybe one person. When asked how the nursing assistants know when to use one or two person to assist a resident, it would depend on how the resident's behavior is that day. The State Surveyor interviewed the Administrator on 05/06/25 and reviewed the care plan and interview with MDS Nurses. The Administrator stated, I agree. when questioning how the nursing assistant would know if the person is a one or two person assist.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide activities intended to enhance the resident's sense of well-being and to promote or enhance physical, cognitive, and emotional health to ensure the resident's highest practicable state of well-being. Resident Identifier: #110. Facility Census:116. Findings Included: a) Resident #110: Resident #110 was diagnosed with cardiomyopathy, heart failure, hypertension, muscle weakness, localized edema, pain in left and right knees, diabetes mellitus - on insulin, and lack of coordination. During an interview with Resident #110 on 04/29/25 at 2:22 PM, the resident stated that he was unable to get out of bed. Upon being asked what activities he has planned for him, the resident said that there isn't much being offered. He reported that he spends his day lying in bed and sometimes watches TV. A review of Resident #110's Care Plan revealed that residents' activity interests were listed as: -Bingo -Hunting -Fishing -Watching TV -Baking -Cooking -Spending time outside -Gardening An observation on 04/30/25, at approximately 3:13 PM revealed the resident in bed. Another observation and interview with the resident, on 05/01/25 at approximately 2:12 PM, revealed the resident was in bed watching TV. Resident stated that he was supposed to have a 1:1 activity, but no one had visited him since 04/23/25. The resident was observed throughout the survey process from 04/29/25 to 05/06/25 and was not observed participating in any activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) provided copies of the resident's activity participation sheets, and activity plan. The documents revealed that the resident had not had any activities from 04/23/25 to 04/30/25. DON confirmed that they were the only participation sheets available for Resident #110. During an interview with Activity Staff (AS) #30 on 05/01/25 at approximately 10:18 AM, it was revealed that resident has been care-planned for self-directed activity. AS #30 stated that resident does not like to go out of his room.

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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 observation, interview, and record review, and staff interview, the facility failed to address and notify the physician about an incorrect medication order. It also neglected to ensure that the order was corrected and updated. This was a random opportunity for discovery. Additionally, the facility failed to complete a Speech Therapy Evaluation per physician's order in a timely manner for Resident #107. This was also a random opportunity for discovery and had the potential to affect a limited number of residents. Resident Identifiers: #221 and #107. Facility Census: 116. Findings Included: a) Resident #221 During observation of medication administration on 05/01/25 at 8:45 AM, RN #19 stated that Resident #221 was prescribed 37.5 MG of Metoprolol. RN #19 further stated that the resident would be administered half (½) a tablet. Inspection of the medication revealed that the pharmacy had provided Metoprolol 75 MG tablets. RN #19 administered Metoprolol 37.5 MG (1/2 tablet) during med pass on 05/01/25 at 8:49 AM. At approximately 10:08 AM on 05/01/25, a review of Resident #221's orders revealed the following order: -Metoprolol Tartrate 50 MG oral tablet. Give 37.5 MG two times a day for HTN [hypertension]. During an interview with RN #19 at 11:15 AM, the RN confirmed that the dose ordered by the physician had been accurately administered. RN #19 also confirmed that the physician's prescription should have stated Metoprolol Tartrate 75 MG. After the surveyor's intervention, at 12:05 PM on 05/01/25, the Director of Nursing (DON) confirmed that the order entered by the physician was inaccurate. The DON further stated that the order would be changed to Metoprolol Tartrate 75 mg tablets. b) Resident #107 On 04/29/25, Resident #107 was observed by the state surveyor in the hallway eating his lunch meal. The resident was coughing while eating. The unit nurse observed the coughing and went to assist the resident. Orders for the following interventions included: CXR STAT Diagnostic Active (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/2025 15:20 GuaiFENesin Liquid 100 MG/5ML Give 10 milliliter by mouth every 4 hours as needed for Cough Pharmacy Active 4/29/2025 19:19 ST to eval and treat as indicated No directions specified for order. Other Active 4/29/2025 Nursing Progress Note stated: 4/29/2025 16:20 Resident noted to have increased coughing this shift. NP [Nurse Practitioner] to assess resident. New orders to start PRN [as needed] tussin 10ml q4h, obtain CXR, CBC, BMP, procal STAT, ST [Speech Therapy] to eval. Orders placed in PCC [electronic medical record] and MPOA [medical power of attorney] aware. Labs drawn and pending pickup at this time. A chest x-ray was completed on 4/30/2025 8:29:06 AM. On 05/05/25 at 12:41 PM, the Administrator confirmed there was no Speech Therapy evaluation per order. The Administrator stated, They didn't do it not happening until today. The resident was not evaluated by speech therapy until surveyor intervention.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interviews, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. This was a random opportunity for discovery of a resident smoking in non-designated areas. Resident Identifier: #79. Facility census 116. Findings included: a) Resident #79 On 04/30/25 at 11:54 AM, surveyor observed Resident #79 smoking outside the front door on the sidewalk. On 05/01/25 at 8:10 AM, there was a second observation of Resident #79 smoking out front of the facility in a non-smoking area. During an interview on 05/01/25 at 8:13 AM, the Assistant Administrator stated that the facility did not have any smokers. During a continued interview on 05/01/25 at 8:15 AM, the Assistant Administrator stated that she was not supposed to be out there smoking, but that's where she goes. He verified at this time that Resident #79 was smoking in a non-smoking area. An observation of the area found no ash can, no fire blanket, nor a fire extinguisher in the vicinity. A No Smoking sign was displayed. During an interview with the Corporate Administrator and the Director of Nursing (DON) on 05/01/25 at 8:19 AM, she stated that Resident #79 was supposed to sign out and go off the facility property, but Resident #79 continues to smoke there. She continued to say that they made the resident a place across the parking lot in a grassy area at the top of a hill to smoke but she won't go over there. The DON stated that the resident was grandfathered in and could smoke at the facility. The DON and Corporate Administrator confirmed Resident #79 was not supposed to smoke in the non-smoking area.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interview, and record review, the facility failed to ensure that the oxygen concentrator for a resident with a tracheostomy was set to deliver the exact dose of oxygen prescribed by the physician. Resident Identifier: #94. Facility Census: 116. Findings included: a) Resident #94 Resident #94 is diagnosed with the following: -Traumatic Brain Injury -Dependence on supplementary oxygen -Seizures -Epilepsy -Paraplegia -Tracheostomy -Gastrostomy. Physicians Orders stated the following: -Cool air mist via trach collar continuous with O2 bled in at 5LPM -Suction via trach and prn (lung sounds pre and post, O2 sat pre and post) every shift and as needed -Trach-Type Shiley Size 6 -Trach care q shift and prn as needed -Replace inner cannula during trach care q day and prn every shift and as needed -Have the same size trach and one size smaller at bedside at all times -Change trach ties Mon, Wed, Fri, and prn -Change suction tubing and canister once per week and prn - every shift every Fri AND as needed -Change O2 Mask and initial and date tubing - every day shift every Fri for 02 mask/tubing care -Trach: Ambu Bag at bedside (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of resident on 04/29/25 08:12 AM, resident was asleep, and the oxygen concentrator was noted to be set to 4.0 Liters per minute. A review of the physician's orders showed that the resident was to receive oxygen at 5 liters per minute. During an observation on 04/30/25 2:00 PM, the oxygen concentrator was noted to be set to deliver 4.0 liters per minute. On 05/01/25 at approximately 12:14 PM during an observation, accompanied by RN #19, the oxygen concentrator was noted to be set to deliver 4.5 liters per minute RN #19 confirmed that the concentrator should be set up to deliver 5.0 liters per minute. RN #19 checked physician's order and confirmed that the physician's order specified 5 Liters per minute. RN #19 adjusted the oxygen concentrator to deliver the prescribed dose.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on record review and staff interview, the facility failed to maintain the dietary staff's appropriate competencies for food service handling. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 116. Findings included: a) Food Safety Certificates The State Food Safety Certificate of training had expired for the Certified Dietary Manager #161 on 02/08/24. -The Certified Dietary Manager #161 renewed the certificate of training on 04/30/25 following survey intervention. The State Food Safety Certificate of training had expired for Dietary Aide #166 on 02/09/24. -On 04/30/25 at 3:44 PM, the Regional Certified Food Manager #189 stated, Dietary Aide #166 had resigned on 04/23/25. Dietary Aide #166 had worked without a Certificate of Training for Food Safety on the following dates:02/10/25, 0214/25, 02/15/25, 02/16/25, 02/17/25, 02/19/25, 02/20/25, 02/21/25, 02/24/25, 02/25/25, 02/25/25, 02/26/25, 02/28/25, 03/01/25, 03/02/25, 03/04/25, 03/05/25, 03/06/25, 03/07/25, 03/10/25, 03/11/25, 03/12/25, 03/14/25, 03/15/25, 03/16/25, 03/18/25, 03/19/25, 03/20/25, 03/21/25, 03/24/25, 03/25/25, 03/28/25, 03/31/25, 04/01/25, 04/02/25, 04/05/25, 04/06/25, 04/07/25, 04/11/25, 04/12/25, 04/13/25, 04/14/25, 04/16/25, 04/17/25, 04/19/25, 04/20/25, 04/21/25 and 04/22/25. The Administrator confirmed the expired certificates, on 05/01/25 at 9:50 AM, and stated the Regional Certified Food Manager #189 had told me yesterday.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and observation, the facility failed to store food in accordance with professional standards for food service safety. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 116. Findings Included: a) On 04/29/25 at 07:15 AM, the kitchen investigation was initiated. Cookies were found in the freezer with an incomplete date (no year). The Regional Certified Food Manager #189 stated, I'll discard. b) On 04/30/25 at 11:50 AM, the A-Wing pantry was investigated. The following items were found: -[NAME] pickles open and not dated -Cotton candy - open and not dated -Refrigerator temperature 76 degrees Fahrenheit. Items in the pantry were confirmed by Licence Practical Nurse #28 at 12:00 PM. c) On 04/30/25 at 12:01 PM, the B-Wing pantry was investigated. The following items were found: -[NAME] John's sandwich was not sealed or dated with a used by date -Multiple Individual juice cups (Orange, Apple and Cranberry) were not dated -Refrigerator temperature was 44 degrees Fahrenheit. Items in the pantry were confirmed by Registered Nurse #19 at 12:09 PM. d) Interview with Regional Food Manager #189 On 05/01/25 at 10:19 AM, the Regional Certified Food Manager #189 stated that opened food items are to be labeled and dated for seven (7) days and items have to be dated in the refrigerator.

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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 ensure one (1) of 29 residents reviewed during the long-term care survey process for Physician Orders for Scope of Treatment (POST) forms completed per directions specified by the [NAME] Virginia Center for End-of-Life Care in conjunction with the [NAME] Virginia Health Care Decisions Act (16-30-1). Resident identifiers: #42. Facility census: 116. Findings included: a) Resident #42 Record review on 04/30/25 at 8:55 AM, revealed section for Section D (Signature of Resident, or Guardian /Medical power of Attorney -MPOA Mandatory) was not completed with a MPOA Signature, a verbal signature in place dated 03/03/24 on Resident #42's active Physician Order for Scope of Treatment Form (POST Form). During an interview on 05/01/25 at 10:08 AM, the Director of Nursing (DON), confirmed Resident #42's POST form was incorrect without an MPOA signature in a timely manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and staff interviews, 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 with regards to water management. This practice had the potential to affect all residents that reside in the facility. Facility census: 116. Findings included: a) Water Management During facility record review of the water management revealed, the documentation was not maintained to prevent growth of water borne pathogens including description of the building water system. The flow diagram did not Identify the buildings water systems for which Legionella control measures are needed. No documentation was provided describing the building water systems using text or testing protocols. On 05/05/25 at 2:20 PM, the Maintenance Director verified the facility did not maintain the water management program. He stated that it would be corrected.