STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507591	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT MORGANTOWN (ALR/ALZ)	50 Harmony Drive MORGANTOWN, WV 26508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments Annual Survey (Alzheimer's/Dementia Special Care Unit) Start Date: 08/04/25 End Date: 08/07/25 Census: 27 Deficiencies were cited.	Z 000		
Z 102	64CSR85-4.1.b. Human Resources-Qualifications 4.1.b. The coordinator shall meet the minimum qualifications which include: 4.1.b.1. A license or degree as a health related professional; 4.1.b.2. A minimum of one year working directly with dementia or Alzheimer's care/patients; and 4.1.b.3. Completion of at least a thirty (30) hour training course by a nationally recognized alzheimer's/dementia care giving resource or association, or have comparable training and experience. Based on record review and interview the Licensee failed to ensure the coordinator of the Alzheimer ' s unit completed at least a 30 hour training course by a nationally recognized Alzheimer's/dementia care giving resource or association. This deficient practice had the potential to affect all residents in the Alzheimer ' s unit. Employee identifier: #48. Census: 27. Findings included:	Z 102	Facility's Plan of Correction Z 102 This is to be completed by the coordinator of the Alzheimer ' s unit or Memory Care Director. He/she is to complete the required 30 total hour training course by a nationally recognized Alzheimer ' s dementia care giving resource or association. The coordinator already has 8 hours of training on file so will complete the remainder of training online and/or in person from organizations such as but not limited to NCCDP, Skills2Care, and Alzheimer ' s Association. Completion Date: 10/6/25	10/06/25

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	A review of the Alzheimer ' s Unit Director ' s personnel file during the survey revealed no evidence of completion of at least a 30 hour training course by a nationally recognized Alzheimer ' s/dementia care giving resource or association. A "Certified Dementia Practitioners" certification dated 06/11/24 through 06/11/26 was present in the file. The course length for the "Certified Dementia Practitioners" course was eight (8) hours. During an interview on 08/07/25 at approximately 11:00 AM, the above information was discussed with the Director of Nursing and the Business Office Manager, who were unable to provide evidence to support that the Alzheimer ' s Unit Director completed a 30 hour training course by a nationally recognized Alzheimer ' s/dementia care giving resource or association.			
Z 104	64CSR85-4.1.d. Human Resources-Orientation & Training 4.1.d. The facility shall provide a minimum of eight (8) hours of documented annual training to all staff on the topics in subdivision 4.1.c. of this subsection. Based on record review and interview the facility failed to provide a minimum of eight (8) hours of documented annual training to all staff on required topics. This deficient practice was found for one (1) of 1 applicable employee reviewed during the survey. This deficient practice had the potential to affect all residents residing in the Memory Care Unit. Census: 27.	Z 104	Facility's Plan of Correction Z 104 This is to be completed by the Executive Director, Healthcare Director, Memory Care, Business Office Manager and/or designated person to ensure 8 hours of training on the required topics occur within the last year. This will be documented in the employee file in order to prove the training was completed. Executive Director will perform monthly audits with Business Office Manager to confirm trainings and review upcoming	10/06/25

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	Findings included: Record review during the survey revealed no documented evidence that the Memory Care Director (MCD) had completed a minimum of 8 hours of training on required topics within the last year. The last documentation of annual training for the MCD was on 03/24/23. On 08/06/25 at approximately 1:00 PM, the above findings were discussed with the Director of Nursing (DON), who was unable to provide documented evidence that the MCD completed 8 hours of training on required topics within the last year.		annual due dates for existing employees to complete the required trainings. Completion Date: 10/6/25	
Z 116	64CSR85-6.2. Assessments & Plans of Care 6.2. Within seven (7) days of admission, an interdisciplinary team including the unit coordinator, a social worker, the activities director, direct care staff and a registered nurse and other professional disciplines as appropriate, shall complete an initial assessment of a new resident which includes at a minimum: a social history; family supports; level of activities of daily living functioning; cognitive level; behavioral impairment; and nutritional status, including weight and nutritional requirements. Based on record review and interview, the Licensee failed to ensure the interdisciplinary team, including all required members, completed an initial assessment for each resident within seven (7) days of admission. This deficient practice was found for one (1) of four (4) residents whose records were reviewed during the survey. Resident identifier: #73. Census: 27.	Z 116	Facility's Plan of Correction Z 116 This is to be completed by the Registered Nurse, Memory Care Director, social worker, direct care staff, and Activity Director. All members of the interdisciplinary team will be participating in the 7-day care plan per regulation code 6.2 in which all parties will sign off on resident care plans. Completion Date: 9/30/25	09/30/25

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	Findings included: A review of Resident #73's 7-day care plan dated 07/04/25 revealed no documented evidence that the Activities Director, a required member of the interdisciplinary team, had participated in the completion of this initial assessment. During an interview on 08/06/25 at approximately 2:30 PM the Director of Nursing said the Activities Director had resigned around the end of June 2025 and a replacement had not yet been hired.			
Z 120	64CSR85-6.6. Assessments & Plans of Care 6.6. The interdisciplinary team shall review, evaluate for effectiveness and revise the resident's assessment and care plan at least quarterly or more frequently as indicated by the changing needs of the resident. Based on record review and interview the Licensee failed to ensure the interdisciplinary team, including all required members, reviewed, evaluated for effectiveness and revised each resident's assessment and care plan at least quarterly. This deficient practice was found for one (1) of four (4) residents whose records were reviewed during the survey. Resident identifier: #77. Census: 27. Findings included: A review of Resident #77's quarterly care plan dated 07/11/25 revealed no documented evidence that the Activities Director, a required member of the interdisciplinary team, had	Z 120	Facility's Plan of Correction Z 120 This is to be completed by the Registered Nurse, Memory Care Director, social worker, direct care staff, and Activity Director. All members of the of the interdisciplinary team will participate in the quarterly or change of condition residents residing in the Alzheimer's/Dementia Unit. Completion Date: 9/30/25	09/30/25

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	participated in the review, evaluation, and revision of the care plan. During an interview on 08/06/25 at approximately 2:30 PM the Director of Nursing said the Activities Director had resigned around the end of June 2025 and a replacement had not yet been hired.			
Z 129	64CSR85-9.2.a.-d. Activities 9.2. The activities program shall be directed by a person who is a therapeutic recreation specialist, occupational therapist, or activities professional who has: 9.2.a. Two years of experience in a social or recreational program in the past five years, one of which was full-time in a resident activities program in a health care setting; 9.2.b. Demonstrated the ability to provide for an ongoing program of activities designed to meet the residents needs; 9.2.c. Completed a training course approved by the state; and 9.2.d. Completed the training required in subdivision 4.1.c. of this rule. Based on record review and interview the Licensee failed to ensure the activities program was directed by a person who met all applicable education and training requirements. This deficient practice had the potential to affect all residents residing in the memory care unit. Census: 27.	Z 129	Facility's Plan of Correction Z 129 This is to be completed by the Executive Director, Activities Director, and/or designated person. The Executive Director will arrange for and/or confirm with the Activities Director that he/she has the education and training requirements. Any new Activities Director that is not certified will receive the necessary training that is needed in order to be compliant with regulation code 9.2 within the first 30 days of employment. Completion Date: 9/30/25	09/30/25

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	Findings included: Record review during the survey found no evidence that the activities program was directed by a person meeting all applicable education and training requirements. On 08/05/25 at approximately 2:00 PM, the Executive Director said the former Activities Director had quit in June 2025 and a replacement had not yet been hired.			
E 000	Initial Comment Annual Survey Start Date: 08/04/25 End Date: 08/07/25 Census: Assisted Living- 65, Memory Care- 27 Deficiencies were cited.	E 000	Facility's Plan of Correction Z 129 This is to be completed by the Executive Director, Activities Director, and/or designated person. The Executive Director will arrange for and/or confirm with the Activities Director that he/she has the education and training requirements. Any new Activities Director that is not certified will receive the necessary training that is needed in order to be compliant with regulation code 9.2 within the first 30 days of employment. Completion Date: 9/30/25	09/30/25
E 149	Administrative Requirements &•:•:•w[<Evc^x^bq5Eq?5b[E00!E5q^K^!Eq<^x<^$[q [?G5b?Iq5E^x^x$5<0Eq<vq?q[<?!<5Eq^?x?IE5< b^v<xK<ExxGE00QExvE5<K?5v?Iq[^bq5E^x^x$	E 149	Facility's Plan of Correction E 149	09/25/25

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	b[E00=<E)E^0E=0<I?55<)^<1•L80Ebb999t Based on record review and interview, the Administrator failed to participate in eight (8) hours of training related to the operation of a residence annually. This deficient practice had the potential to affect all residents in the facility. Census: Assisted Living- 65, Memory Care- 27. Findings included: A review of the Administrator/Executive Director ' s personnel file during the survey revealed no documented evidence that the Administrator/Executive Director had participated in 8 hours of training related to the operation of a residence within the last year. On 08/06/25 at approximately 2:00 PM, the Administrator/Executive Director confirmed he had not completed training related to the operation of a residence since 2023.		The Administrator will participate in eight hours of training related to the operation of a residence annually either in person or via online courses. This will be completed through the statewide training provided by the West Virginia Healthcare Association. Completion Date: 9/25/25	
E 146	Administrative Requirements &•l•*•w[<0^K<xb<<b[E005<!?5qcEy?5^xK^v<xqbEb v<l^x<v^xb<Kq^?xl•l:•?Iq[^b5G0<q?q[<|II^K<?Ik<E 0q[oEK^0^qQU^K<xbG5<Exv8<5q^I^KEq^?xEbb ??xEb!?bb^=0<Exvx?0Eq<5q[Exq[<x<Oq=Gb^x <bbvEQ•L80Ebb999t Based on record review and interview the Licensee failed to ensure major incidents were reported to the Office of Health Facility Licensure and Certification (OHFLAC) no later than the next business day. This deficient practice was	E 146	Facility's Plan of Correction E 146 The Executive Director, Healthcare Director, Memory Care Director and/or designated nursing employee will report major incidents no later than the next business day. Major incidents will either be faxed or emailed over. Executive Director will follow up with clinical staff following major incidents to ensure protocol is executed. Completion Date: 9/11/25	09/11/25

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	found for one (1) of 11 applicable residents whose records were reviewed during the survey. Census: Assisted Living- 65, Memory Care- 27. Findings included: A review of major incident forms during the survey revealed Resident #19 experienced an accident on 05/12/25 at 2:30 PM. Further record review revealed Resident #19 ' s accident was not reported to OHFLAC until 05/20/25 at 11:30 AM. During an interview on 08/06/25 at approximately 11:30 AM the Executive Director they would make sure to update OHFLAC about major incidents.			
E 154	Administrative Requirements &•&•4•=•>)<x^x$b[^Iq29xEvv^q^?xq?q[<?x<v^5<KqKE5<!<5b?x?xq[<<)<x^x$b[^Iqq[<5<b^v<xK<b[E00[E)<Eq0<Ebq?x<Evv^q^?xE0v^5<KqKE5<bqEII?xq[<<)<x^x$b[^IqI?5<EK[4~5<b^v<xqb^v<xq^I^<v?xq[<^5IGxKq^?xE0x<<vbEbb<bbc<xqbq?[E)<q1??5c?5<b!<K^E0KE5<x<<vb@ Based on record review and interview the Licensee failed to ensure adequate staffing levels during the evening shift. This deficient practice had the potential to affect more than an isolated number of residents. Census: Assisted Living- 65, Memory Care- 27. Findings included: Record review during the survey found there were 35 residents with two (2) or more care needs residing in Assisted Living, necessitating a	E 154	Facility's Plan of Correction E 154 The Executive Director, Healthcare Director, Memory Care Director, and/or designated scheduler will ensure the proper number of direct care personnel are staffed in relation to the number of residents requiring assistance with two or more ADL's. This also includes staffing at least 1 additional direct care staff on the evening shift for each 15 residents identified on their functional needs assessments or more special care needs. Completion Date: 9/22/25	09/22/25

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	minimum of three (3) direct care staff on the evening shift. A review of the daily staffing sheets from 07/01/25 - 07/31/25 during the survey found there were only two (2) direct care staff working after 7:00 PM in Assisted Living on the following dates: 07/04/25, 07/05/25, 07/12/25, and 07/13/25 During an interview on 08/07/25 at approximately 10:00 AM the Healthcare Director said, "We have been short staffed on certain days. We have notified Corporate we have been short staffed for a while now."			
E 173	Administrative Requirements &•H•X•w[<0^K<xb<<b[E00cE^xqE^xE5<$^bq<5?IE 005<b^v<xqb^x?5v<5=Qq[<vEq<b?Iq[<5<b^v<x qb(Evc^bb^?xb•w[<5<$^bq<5b[E00^xK0Gv<<EK[5<b^v<xq(bxEc<q[<vEq<?IEvc^bb^?xq[<vEq<?I[^b?5[<50EbqvEQ^xq[<5<b^v<xK<Exv^Iq5ExbI< 55<vq[<xEc<?Iq[<!0EK<q?1[^K[q[<5<b^v<xq1Eb q5ExbI<55<v•L80Ebb999t Based on record review and interview, the Licensee failed to maintain a register of all residents. This deficient practice had the potential to affect 19 of 19 residents who were living in the facility but not listed on the register. Resident identifiers: 16, 17, 22, 31, 32, 33, 36, 37, 40, 42, 44, 51, 53, 57, 61, 71, 77, 78, and 81. Census: Assisted Living- 65, Memory Care- 27. Findings included:	E 173	Facility's Plan of Correction E 173 The Executive Director, Business Office Manager, Healthcare Director will update the register as needed on an ongoing basis to match the current resident roster as well as the historical information as it relates to resident ' s name, admission date, last day of residency, and name of place resident transfers from the community. The registry will include all necessary criteria required by regulation code 4.7.8. Completion Date: 9/22/25	09/22/25

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	A review of the resident roster and resident register provided during the survey revealed Residents #16, #17, #22, #31, #32, #33, #36, #37, #40, #42, #44, #51, #53, #57, #61, #71, #77, #78, and #81 resided in the facility, but they were not listed on the resident register. During an interview on 08/05/25 at approximately 2:20 PM, the Business Office Manager said they were not aware of the issue and had received conflicting information as to how to maintain the register.			
E 235	Health Care Standards *•&•4•w[<0^K<xb<<b[E00<xbG5<q[Eq5<b^v<xqKE 5<^b!5?)^v<v=QE!!5?!5^Eq<0Q0^K<xb<v[<E0q[KE5<!5?I<bb^?xE0bExvq[Eqc<v^KEq^?xbExvq5 <Eqc<xqb$^)<xq?5<b^v<xqbE5<Evc^x^bq<5<vE b5<eG^5<v=QE!!0^KE=0<I<v<5E0ExvbqEq<0E 1^xK0Gv^x$W•ME•8?v<§§4*"24d24<qb<e•Exv|II^K <?I9xb!<Kq?5n<x<5E0U<$^b0Eq^)<%G0<p<0< $Eq^?x?I;<v^KEq^?xrvc^x^bq5Eq^?xExvP<5I?5 cExK<?Ik<E0q[;E^xq<xExK<wEbYb=Qr!!5?)<v;< v^KEq^?xrbb^bq^)<P<5b?xx<0W•ME•8?v<%•§§H4 24H24<qb<e•L80Ebb9t Based on record review and interview the Licensee failed to ensure their Approved Medication Administration Personnel (AMAP) manual was maintained in accordance with the AMAP Rule and that only licensed staff administered injections other than prefilled insulin or insulin pens. This deficient practice affected four (4) of 4 applicable residents who received unauthorized injections from unlicensed staff and had the potential to affect all residents in the facility. Resident identifiers: #13, #16, #33, and #61. Employee identifiers: #22, #49, #55, #64,	E 235	Facility's Plan of Correction E 235 The licensee shall ensure non-insulin injections are administered from licensed nursing professionals or the resident if the resident can safely administer medication and has successfully passed the self-administration assessment. Education/training will occur with AMAP personnel to ensure AMAP employees are fully aware of the AMAP policy among initial training and for existing AMAP personnel. The Licensee shall ensure the AMAP manual includes policies regarding administrative lifesaving medications, ongoing review of the medication administration records and treatment administration records, and withdrawal of approval for an AMAP to perform authorized and permitted delegated tasks. Completion Date: 10/1/25	10/01/25

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	and #77. Census: Assisted Living- 65, Memory Care- 27. Findings included: a.) Review of AMAP Manual A review of the Licensee ' s AMAP manual during the survey revealed no evidence of the following required policies: -Administering lifesaving medications, -Ongoing review of the medication administration records and treatment administration records, and -Withdrawal of approval for an AMAP to perform authorized and permitted delegated tasks. Further review revealed no evidence that the AMAP manual was reviewed for any updates or needed revisions within the last year. The last documented review occurred on 02/09/23. During an interview on 08/07/25 at approximately 10:00 AM the AMAP Registered Nurse stated she would give this information to Corporate to address. b.) Resident #13 A review of Resident #13's medication administration record (MAR) during the survey revealed Employee #77, an AMAP employee, administered an injection of Mounjaro to Resident #13 on 07/19/25 at 8:00 AM. Further review of Resident #13 ' s MAR revealed Employee #55, an AMAP employee, administered an injection of Mounjaro to Resident #13 on both 07/12/25 and 07/26/25 at			

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HARMONY AT MORGANTOWN (ALR/ALZ)	50 Harmony Drive MORGANTOWN, WV 26508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	8:00 AM. c.) Resident #16 A review of Resident #16's MAR during the survey revealed Employee #22, an AMAP employee, administered an injection of Ozempic to Resident #16 on both 07/17/25 and 07/31/25 at 8:00 AM. d.) Resident #33 A review of Resident #33's MAR during the survey revealed Employee #49, an AMAP employee, administered an injection of Ozempic to Resident #33 on 07/03/25 at 8:00 AM. e.) Resident #61 A review of Resident #61's MAR during the survey revealed Employee #64, an AMAP employee, administered an injection of Forteo to Resident #61 on the following dates and times: -07/11/25 at 9:00 PM, -07/12/25 at 9:00 PM, -07/13/25 at 9:00 PM, -07/17/25 at 9:00 PM, -07/18/25 at 9:00 PM, -07/21/25 at 9:00 PM, -07/22/25 at 9:00 PM, -07/23/25 at 9:00 PM, -07/24/25 at 9:00 PM, -07/29/25 at 9:00 PM, -07/30/25 at 9:00 PM, and -07/31/25 at 9:00 PM. f.) Interview During an interview on 08/07/25 at approximately			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507591	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	2:00 PM, the Director of Nursing stated she had trained all AMAP employees to administer injections, stating she was unaware the only injections that AMAPs could administer were prefilled insulin or insulin in a pen.			
E 291	Physical Facilities 4d•4•~•w[<0^K<xb<<b[E00Y<<!q[<5<b^v<xK<l5<<?l^xb<Kqb5?v<xqbExv)<5c^x•L80Ebb999t Based on observation and interview the Licensee failed to keep the residence free of insects. This deficient practice had the potential to affect more than an isolated number of residents. Census: Assisted Living- 65, Memory Care- 27. Findings included: During the survey there were tiny black flying insects observed in the dining room, the private dining room, and the common area. Tiny black flying insects were also observed during a tour of the kitchen on 08/06/25 at approximately 2:00 PM. During an interview on 08/07/25 at approximately 11:00 AM the Director of Nursing and the Business Office Manager agreed there were "fruit fly" insects in the facility.	E 291	Facility's Plan of Correction E 291 This is to be completed by the Executive Director, Maintenance Director, or designated person. Licensee shall ensure that proper preventative measures are taken to keep the residence free of insects. This includes preventative maintenance treatments and to extermination methods to remove insects from the community. The licensee will be working with local extermination provider to eliminate the insects. Completion Date: 9/26/25	09/26/25