STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515147	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Valley Center	422 23rd Street Oak Hill, WV 25901

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31826 Based on observation and staff interview the facility failed to ensure Resident #19 had a dignified dining experience during the noon time meal on 04/23/24. The facility failed to serve Resident #19 at the time her peers in the same dining area were served. Resident #19 was not served for 30 minutes after the last resident in the same dining room was served their meal. For Resident #18 the facility failed to ensure dignity while she was using the bedside commode. These were random opportunities for discovery and were true for Resident #19 and Resident #18. Resident Identifiers: #19 and #18. Facility Census: 76. Findings Include: a) Resident #19 An observation of the noon time meal began at 11:40 AM on 04/23/24. Upon entering the dining room it was noted Resident #19 was sitting at a table by herself in the back dining room. Also seated in the dining room were seven (7) additional residents. At 12:00 PM the last tray was served to the seven (7) additional residents. Activity Assistant #18 picked up Resident #19's tray and asked Nurse Aide (NA) #5 who was going to feed (Resident #19's Name). NA #5 stated, Just set it over there and when we are done feeding here we will feed her. Activity Assistant #18 returned Resident #19's food to the serving tray area. During this time NA #5, NA #31 and Licensed Practical Nurse (LPN) #78 were assisting other residents with their meals. Resident #19 remained at her table talking to herself and the resident was picking at the table simulating she was picking up items which were really not there. She would then move her hand to her mouth as if she was eating the items she simulated picking up. This continued for 30 minutes. At 12:30 PM on 04/23/24 , LPN #78 asked the Activity Assistant to get Resident #19 a new tray and she would feed her. A new tray was obtained from the kitchen. At this time LPN #78 was questioned about why Resident #19 was not fed for 30 minutes while everyone else in the dining room was eating. She stated, I guess there were just not enough hands on deck. Usually there is another nurse in here. I don't know what happened today. She stated, It's not fair she had to watch everyone else eat. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:50 PM on 04/23/24 an interview with the Nursing Home Administrator, the Nurse Practice Educator and Unit Manager # 40 found the Director of Nursing (DON) was assigned to the dining room today and she is on vacation so they were down a nurse during the noon time meal in the dining room. The Nursing Home Administrator indicated the Nurse Aide should have left the dining room to get someone to come help because there were plenty of people available that could have fed Resident #19. a) Resident #18 On 04/23/24 at 9:06 AM, Resident #18 was observed to be using a bedside commode sitting directly in front of the residents window that faces the neighboring residential area outside. The window blind was not pulled, the resident door was open and no privacy curtain was pulled. Resident #18 stood herself up in front of the window and wiped herself. Licensed Practical Nurse (LPN) #76, was outside the room at her medication cart and when made aware of what was observed, stated she did not think she had capacity but as a reasonable person she would not had wanted to use the bedside commode with the blind not pulled, the room door open and no privacy curtain pulled. Staff #76 stated to the Certified Nursing Assistant (CNA) #5 who passed in the hallway at this time to make sure she is pulling the blind and curtain when Resident #18 is using her bedside commode. On 04/23/24 at approximately 10:00 AM, during a medical record review of Resident #18's care plan dated 01/30/24, it was identified Resident #18 is care planned with a focus for the resident being incontinent of bowel and bladder, it was further identified as an intervention, the resident is care planned to be provided privacy and comfort. On 04/23/24 at approximately 10:25 AM, during an interview with the Unit Manager Licensed Practical Nurse (UM LPN) #38, she acknowledged Resident #18 was care planned for privacy and comfort. She further acknowledged the bedside commode sits directly in front of the window which faces the neighboring residential area and stated the staff should have pulled down the blind on the window. She further stated they should have pulled the privacy curtain and or shut the room door. 49650

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31826 Based on record review, observation and staff interview the facility failed to ensure Resident #4's accident care plan was implemented. This was a random opportunity for discovery and was true for Resident #4. Resident Identifier: #4. Facility Census: 76. Findings included: A) Resident #4 A review of Resident #4's medical record in the afternoon of 04/23/24 found a care plan with the following focus statement, Resident has a history of falls and is at risk for further falls related to impaired mobility, incontinence. Huntington's Disease. This care plan was initiated on 07/07/22. A review of the interventions related to this focus statement found an intervention which read, left side of bed against wall. This intervention was added to the care plan on 04/05/24. An observation of Resident #4 at 4:15 PM on 04/23/24 with the Nursing Home Administrator present found Resident #4's bed was not against the wall. The resident was laying in the bed and the head of the bed was against the wall and a fall mat was laying on either side of the bed.

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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. 49650 Based on observation, medical record review and staff interview, the facility failed to revise the comprehensive care plan for the use of a bedside commode. This was a random opportunity for discovery and was true for Resident #18. Resident identifier #18. Census: 76. Findings included: a) Resident #18 On 04/23/24 at 9:06 AM, Resident #18 was observed using a bedside commode sitting directly in front of the residents window which faced the neighboring residential area outside. The window blind was not pulled, the resident door was open and no privacy curtain was pulled. Resident #18 stood herself up, in front of the opened window, and wiped herself. Licensed Practical Nurse (LPN) #76, was outside the room at her medication cart and when made aware of what was observed, stated she did not think she had capacity but as a reasonable person she would not have wanted to use the bedside commode with the blind not pulled, the room door open and no privacy curtain pulled. Staff #76 stated to the Certified Nursing Assistant (CNA) #5 who passed in the hallway at this time to make sure she was pulling the blind and curtain when Resident #18 was using her bedside commode. On 04/23/24 at approximately 10:00 AM, during a medical record review for Resident #18, it was identified the resident was care planned for being incontinent of bowel and bladder. It was further identified that the resident was not care planned for the use of a bedside commode. During an interview with Unit Manager Licensed Practical Nurse (UM LPN) #38 on 04/23/24 at 10:25 AM she acknowledged the care plan had not been revised when the bedside commode was put in place and she was correcting it now.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31826 Based on record review and staff interview the facility failed to follow physician orders for Resident #3 to have accu checks three (3) times a day. This was true for one (1) of 20 sampled residents. Resident Identifier: #3. Facility Census: 76. Findings Include: a) Resident #3 A review of Resident #3's medical record on 04/22/24 found a physician order for Accu Check TID (three times a day). Notify Physician if blood sugar is less than 70 or greater than 450. This order was dated 03/18/24 and was the current order at the time of this review. A review of the medication administration record (MAR) and the blood sugar vital signs tab in the electronic medical record found the facility had not obtained a blood sugar since 04/09/24 at 10:20 am. The facility had missed obtaining the blood sugar for 13 days at the time of this review. During an interview with the Nursing Home Administrator, Nurse Practice Educator, and Unit Manager #40 on 04/23/24 at 12:56 PM the above findings were discussed. At 2:25 PM on 04/23/24, Unit Manager #40 confirmed there was no blood sugars documented since 04/09/24 at 10:20 AM. She indicated one of the nurses had edited the order and removed the supplement documentation so it was not being documented and she was not sure if it was being done or not because it was not documented.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review, observation, and staff interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Resident #1 was assessed to be transferred with a total lift with the assistance of two (2) people. There were several occasions the staff indicated in their documentation he was transferred inappropriately. For Resident #4 the facility failed to implement a fall intervention. This was true for two (2) of four (4) sampled residents. Resident Identifiers: Resident #1 and Resident #4. Facility Census: 76. Findings included: a) Resident #1 A review of Resident #1's medical record in the afternoon of 04/22/24 found two (2) Lift transfer evaluations. The lift transfer evaluations were dated 08/28/23 and 11/28/23. Both lift transfer assessments indicated Resident #1 needed to be transferred with total body lift with a two person assist. The resident had a diagnosis of paraplegia, and contractures at the knees and hips. Resident # 1 was admitted to the facility on [DATE] and discharged from the facility on 11/30/23. A review of his activities of daily living documentation for the entire length of his his stay found the following: Resident #1 was documented as being independent in his transfers a total of three (3) times. Resident #1 was transferred with supervision and setup help only a total of three (3) times. Resident #1 was transferred with a limited assist with the assistance of one (1) person 20 times. Resident #1 was transferred with an extensive assist with the assistance of one (1) person a total of 32 times. Resident #1 was transferred with an extensive assist with the assistance of two (2) people a total of 55 times. Resident #1 during his admission was transferred a total of 138 times. Of those 138 times he was transferred incorrectly 113 times. An interview with the Nurse Practice Educator, Unit Manager # 40 and the Nursing Home Administrator on 04/23/24 at 1:40 PM the above findings were discussed. Unit Manger #40 stated she would look into it. Later in the afternoon Unit Manger #40 presented discharge notes from physical therapy which indicated the resident could be discharged home with a sliding board for transfers. These notes were dated 11/30/23 which was the date of Resident #1's discharge. The therapy notes contained no indication Resident #1 was able to transfer himself with a sliding board while a resident at the facility. b) Resident #4 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #4's medical record in the afternoon of 04/23/24 found a care plan with the following focus statement, Resident has a history of falls and is at risk for further falls related to impaired mobility, incontinence. Huntington's Disease. This care plan was initiated on 07/07/22. A review of the interventions related to this focus statement found an intervention which read, left side of bed against wall. This intervention was added to the care plan on 04/05/24. An observation of Resident #4 at 4:15 PM on 04/23/24 with the Nursing Home Administrator present found Resident #4's bed was not against the wall. The resident was laying in the bed and the head of the bed was against the wall and a fall mat was laying on either side of the bed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 31826 Based on observation and staff interview the facility failed to deploy available staff in a manner which ensured Resident #19 was fed her noontime meal in a timely manner. Resident #19 was not assisted with her noon time meal for 30 minutes after the last resident in the same dining room was served their meal. This was a random opportunity for discovery and was true for Resident #19. Resident Identifiers: #19. Facility Census: 76. Findings Include: a) Resident #19 An observation of the lunch meal began at 11:40 AM on 04/23/24. Upon entering the dining room it was noted Resident #19 was sitting at a table by herself in the back dining room. Also seated in the dining room were seven (7) additional residents. At 12:00 PM the last tray was served to the seven (7) additional residents. Activity Assistant #18 picked up Resident #19's tray and asked Nurse Aide (NA) #5 who was going to feed (Resident #19's Name). NA #5 stated, Just set it over there and when we are done feeding here we will feed her. Activity Assistant #18 returned Resident #19's food to the serving tray area. During this time NA #5, NA #31 and Licensed Practical Nurse (LPN) #78 were assisting other residents with their meals. Resident #19 remained at her table talking to herself and the resident was picking at the table simulating she was picking up items which were really not there. She would then move her hand to her mouth as if she was eating the items she simulated picking up. This continued for 30 minutes. At 12:30 PM on 04/23/24 , LPN #78 asked the Activity Assistant to get Resident #19 a new tray and she would feed her. A new tray was obtained from the kitchen. At this time LPN #78 was questioned about why Resident #19 was not fed for 30 minutes while everyone else in the dining room was eating. She stated, I guess there were just not enough hands on deck. Usually there is another nurse in here. I don't know what happened today. She stated, It's not fair she had to watch everyone else eat. At 12:50 PM on 04/23/24 an interview with the Nursing Home Administrator, the Nurse Practice Educator and Unit Manager # 40 found the Director of Nursing (DON) was assigned to the dining room today and she is on vacation so they were down a nurse during the noon time meal in the dining room. The Nursing Home Administrator indicated the Nurse Aide should have left the dining room to get someone to come help because there were plenty of people available that could have fed Resident #19.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49650 Based on observation and staff interview the facility failed to post accurate data on the nursing staffing data forms to include the total number of staff and or the actual hours worked by the certified nursing assistants. This was true for two (2) of nine (9) daily nursing staffing forms reviewed. This had the potential to affect a limited number of residents. Inaccurate dates identifier: 03/09/24 and 03/10/24. Census; 76. Findings include: a) 03/09/24 On 04/23/24 at 10:40 AM during a review of the staffing posting form it was identified the facility did not have documented on the form the Certified Nursing Assistant (CNA) staffing numbers or the CNA scheduled hours for the 07:00 AM to 03:00 PM hours. Further review of the schedule provided for 03/09/24 the CNA staffing numbers and scheduled hours were able to be identified. On 04/23/24 at 10:49 AM, during an interview with the Administrator, she acknowledged the staffing posting form was not correct as the required information was not listed to identify the CNA staffing numbers and the CNA scheduled hours for the 07:00 AM to 03:00 PM hours. b) 03/10/24 On 04/24/24 at approximately 9:30 AM during a review of the staffing posting form and the Time Detail report, it was identified the staffing posting form did not accurately identify the total number of certified nursing assistants (CNA) who worked or the accurate number of hours worked for the 07:00 AM to 03:00 PM shift and the 03:00 PM to 11:00 PM shift. The staffing posting form was documented for the 07:00 AM to 03:00 PM shift to have three (3) CNA's at a total of 24 hours, the time detail report identified four (4) CNA's with 32 hours worked; the staffing posting form was further documented on the 03:00 PM to 11:00 PM to have a total of 5.5 CNA's and a total of 27 hours, the time deal report identified the total of CNA's to be 6 (six) and the total number of hours worked to be 22. On 04/24/24 at approximately 10:15 AM during an interview with the Administrator, she acknowledged the staffing posting forms were not completed with accurate data. She stated she would be addressing the issue.

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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. 49650 Based on observation and staff interview the facility failed to distribute and serve food in accordance with professional standards for food service safety by activity staff serving ice cream on the unit. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Facility Census; 76 Findings Include: a) Ice Cream On 04/23/24 at 02:20 PM during a tour of the facility, Activities Assistant (AA) #18 was observed to be pushing a cart down Unit A with 5 open containers of vanilla ice cream. AA #18 stated she was serving the residents ice cream in their rooms if they wanted it. AA #18 stated she was told to prepare the open containers and place them on the cart without lids or covering the containers and to take it out on the floor to distribute. The Activities Director (AD) #14 was in the hallway at this time and acknowledged the open containers of ice cream should not be on the floor without being covered or having lids on them.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review and staff interview the facility failed to ensure Resident #2's medical record was complete and accurate. There was a nutritional assessment which indicated the resident had a significant weight gain when in fact she had not. This was true for one (1) of 20 sampled residents. Resident identifier: #2. Facility Census: 76. Findings include: A) Resident #2 A review of Resident #2's medical record found a nutritional assessment dated [DATE]. This assessment under the section weight status indicated Resident #2 had a 5.1 percent weight gain in a period of one (1) month. This signified a significant weight gain. A review of Resident #2's medical record found the resident weighed 141 pounds on 03/27/24. A month previous she weighed 140.5 pound on 02/28/24. This was a gain of only one half of a pound. This is not a weight gain of 5.1 percent as indicated on the assessment completed on 03/27/24. An interview with the Nursing Home Administrator, the Nurse Practice Educator, and Unit Manager #40 at 1:02 PM on 04/23/24 confirmed this assessment was inaccurate.

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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. 45171 Based on observation and staff interview 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. This was a random opportunity of discovery. This had the potential to affect more than an isolated number of residents. Facility Census: #76 Findings included: a) Memory unit Bathtub On 04/24/24 at 9:45 AM, an observation of the walk-in bathtub on the memory unit (Mary's Garden) found two items of clothing with a dark brown substance on them located in the bathtub. This was confirmed with the memory unit Director #35 on 04/24/24 at 9:53 AM at which time she confirmed the clothing items should not be in the tub. b) Memory unit shower room On 04/24/24 at 9:46 AM, an observation of the shower on the memory unit (Mary's Garden) found two washcloths on the floor of the shower. One appeared wet and had a dark brown substance on it while the other appeared wet. This was confirmed with the memory unit Director #35 on 04/24/24 at 9:53 AM at which time she confirmed the items should not be in the shower floor. (c) Memory unit walk in tub hand held spray nozzle On 04/24/24 at 09:47 AM observation of the walk-in bathtub on the memory unit (Mary's Garden) found the hand held spray nozzle had a black substance coming out of the holes on the spray nozzle. This was confirmed with the memory unit Director #35 on 04/24/24 at 9:53 AM at which time she stated she did not know what the substance was but it did not belong there. d) soiled towel and soiled washcloth On 04/22/24 at 3:17 PM during a tour of the facility, a soiled towel and a soiled washcloth was observed to be lying on the floor of Unit A's small shower room. On 04/22/24 at 3:20 PM during an interview with the Infection Control Registered Nurse (IC RN) #34, she stated the staff has been educated numerous times about not leaving soiled linens on the floor. She acknowledged the soiled linens being on the floor and picked them up at this time and placed them in a bag. 49650