

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2025
NAME OF PROVIDER OR SUPPLIER  Hidden Valley Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff, hospital, and ombudsman interviews, the facility failed to ensure Resident #80 was permitted to return to the facility following a hospitalization for behavioral evaluation. The facility's refusal to readmit the resident was based solely on behaviors that occurred prior to the hospitalization. This deficient practice resulted in an involuntary discharge without adherence to federal discharge requirements. Resident Identifier: #80 Facility Census: 77 Findings include: Record review revealed Resident #80 was transferred to hospital on [DATE] due to aggressive behavior and bipolar disorder. Progress notes from [DATE] documented that the resident exhibited increased agitation, verbal aggression, and non-redirectable behaviors, and was sent to the hospital for further evaluation per physician order. Further review of nursing documentation showed multiple instances of behavioral escalation throughout [DATE], including verbal aggression toward staff, sexually inappropriate comments, and threats directed at staff. The facility addressed these behaviors through 1:1 observation, medication adjustments, and staff re-education regarding abuse reporting requirements. A Social Services note dated [DATE] indicated that discharge MDS sections were completed with the return anticipated. However, the resident was not readmitted following hospitalization. Interview with the Hospital Care Manager (#98) on [DATE] revealed multiple attempts were made by the hospital to discharge Resident #80 back to the facility. The hospital was informed by the facility that the resident could not return to the building or to any facility owned/operated by the same company. The Care Manager further stated the facility did not inform the hospital at the time of transfer that the resident would not be accepted back. Interview with the Ombudsman on [DATE] 12:00 PM revealed she was made aware that Resident #80 had been sent to the hospital and not brought back. The Ombudsman reported contacting the facility administrator at that time and was told by the administrator that she had no plan to assist with the discharge or return of the resident. The Ombudsman stated she informed the administrator that the facility was responsible for the resident's readmission. There was no documentation to show that the facility: Completed a discharge notice that met the requirements of S483.15(c); Involved the resident and representative in the discharge planning process; Documented that the resident's needs could not be met in the facility; or Made efforts to determine reasonable accommodations or interventions to support the resident's return. Review of available bed census confirmed that the facility had an available bed on and after the date the resident's hospital bed-hold expired. During interview with the Administrator on [DATE] at 3:00 PM, she confirmed the facility declined to readmit Resident #80 due to behavioral issues exhibited prior to hospitalization and acknowledged that no discharge notice was issued.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 515147
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on record review and interviews, the facility failed to provide required written notice to the resident, resident representative, and the long-term care ombudsman prior to discharging Resident #80 and refusing readmission following hospitalization. The facility's failure to issue appropriate notice deprived the resident and representative of their right to appeal and participate in discharge planning. Resident Identifier: #80 Facility Census: 77 Finding Include: Record review showed Resident #80 was transferred to hospital on 8/31/25 and remained hospitalized beyond the bed-hold period. Despite hospital documentation showing the resident was ready for return, the facility declined readmission. Interviews with the Hospital Care Manager and Ombudsman confirmed the resident and representative were not notified in writing of the facility's decision to refuse return. There was no evidence that: A written discharge notice was provided to the resident and representative; The notice contained the reason for discharge, effective date, and appeal rights; The state long-term care ombudsman received a copy of the notice; or Discharge planning was coordinated with the hospital and community services. Interview with the Administrator confirmed that a written notice was not issued prior to refusing the resident's readmission. This failure resulted in an involuntary discharge without the required written notice, denial of appeal rights, and inadequate discharge planning in violation of S483.15(c)</p>		