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	04/22/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure they implemented their policy on abuse to ensure allegations of abuse were properly identified, reported, and thoroughly investigated in accordance with the facility's abuse prevention policies. This deficient practice placed residents at risk for unrecognized and unaddressed abuse. Resident identifier: #25. Facility census: 74. Findings included:a) Resident #25On 04/20/26 at approximately 12:59 PM, the surveyor interviewed Administrator #18. During the interview, the Administrator acknowledged observing Resident #25 unclothed and confirmed the incident occurred. However, the Administrator stated the facility did not classify the incident as an allegation of sexual abuse. The Administrator reported, I think because she was fully clothed. There was no evidence of her being touched. The Administrator further indicated that the facility conducted interviews and completed a skin assessment as part of its review process.On 04/20/2026 at approximately 12:59 PM, the surveyor interviewed Administrator #18. During the interview, the Administrator acknowledged a resident was observed unclothed and confirmed the incident occurred within the facility. The Administrator stated the facility did not classify the incident as an allegation of sexual abuse, reporting, I think because she was fully clothed. There was no evidence of her being touched. The Administrator further indicated staff interviewed the individuals involved and completed skin assessments of the residents.A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revealed residents had the right to be free from abuse, including sexual and physical abuse. The policy further indicated that the facility maintained a facility-wide commitment and allocated resources to protect residents from abuse by anyone, including other residents. The policy required the facility to establish and implement a QAPI review and analysis process for reports, allegations, or findings of abuse.A review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy revealed all reports of resident abuse were to be reported and thoroughly investigated by facility management. The policy further directed that findings of all investigations were to be documented and reported.These findings were reviewed and confirmed with Corporate Nurse #80 on 04/21/2026 at approximately 10:00 AM.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview the facility failed to report an allegation of physical abuse between residents within two (2) hours of the incident. This was discovered during an investigation into a Facility Reported Incident (FRI) and was true for Resident #28. Resident Identifier: #28. Facility Census: 74. Findings Include: a) Resident #28 A review of a Facility Reported Incident (FRI) dated 11/09/24 found the following: A co-resident punched the resident in the shoulder. An X-ray was completed, and the resident was not injured. The incident occurred on 11/09/24 at 12:40 PM. A further review of the initial report showed it was filed on 11/09/24 but no time was identified. A further review of the information provided by the facility found no fax confirmation sheet to identify when the facility submitted the report. The five-day follow-up was reviewed and showed the fax confirmation sheet was attached, indicating when the five-day follow-up was submitted. The nursing home administrator (NHA) was asked to provide the fax confirmation sheet for the initial report filed on 11/09/24. On the afternoon of 04/21/26 the NHA confirmed she could not find anything that would prove what time the initial report was filed.

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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 a review of a facility reported incident (FRI) and staff interview it was determiend the facility failed to use the results of the investigation to determine the appropriate action to take regarding education of staff following a resident's fall with major injury. Resident identifier: #78. Facility census: 74. a) Resident #78 An investigation for a Facility Reported Incident (FRI) was initiated on 04/20/26. A random discovery was found pertaining to an additional FRI dated 06/13/25 that was reviewed during the investigation. It was determined the facility failed to implement corrective action for staff education following a fall with major injury for Resident #78 for FRI dated 06/13/25. The Initial Report of Allegations dated 06/13/25 stated the resident had a fall and was sent to the hospital. The hospital called the facility and stated the resident had a fracture of the right shoulder and collarbone on 06/14/26. The Five-Day Follow-Up Investigation Report, submitted 06/18/25, stated the nurse assessed the resident for injuries, noting a hematoma to the top right side of her scalp at the time of the incident. Resident complained of right knee pain on assessment. The resident's Medical Power of Attorney requested the resident be sent to the Emergency Room. A verbal report from the emergency room was received by the facility that the resident had sustained a right scapula fracture. The facility's actions to be taken as a result of the investigation or allegation stated, All staff are being educated on safe resident handling. Education provided to the state surveyor was completed on 06/18/25 for two (2) nurse aides only. No training was provided to additional staff members. Corporate Registered Nurse #80 confirmed two (2) staff members were educated for the FRI dated 06/13/25. \

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on resident interview, staff interview, record review and observation, the facility failed to ensure a call light was placed within a resident's reach while in bed. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #40. Facility Census: 74.Findings included: a) Resident #40 On 04/13/26 at 3:00 PM, during the initial interview process, Resident #40's call light was behind the resident's headboard, on the floor, and tangled in cords under the bed. When the state surveyor asked the resident where his call light was, the resident patted his blanket and pillow and reported he didn't know its location. At 3:11 PM, Nurse Aide #41 confirmed the call light's location, retrieved it, and fastened it to the resident's blanket. b) Resident #40's Care Plan stated that the resident is at risk for falls and required staff to place call light within reach while in bed or close proximity to the bed. c) The facility's policy and procedure for Call Lights stated, 4. Staff will ensure the call light is within reach of the patient and secured as needed.