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	10/01/2024

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

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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	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 #44 was afforded the right for a dignified experience while using the restroom. This was a random opportunity for discovery and was true for Resident #44. Facility Census: 77. Finding included: a) Resident #44 On 09/25/24 at 8:57 AM, while walking down the hall toward Resident #44's room the surveyor observed Resident #44 sitting on the toilet with her pants down in the bathroom. Both the bathroom door and the room door were open, and the resident could be seen from the hallway. The Director of Rehab and Speech Therapist were across the hall. When the surveyor asked if someone could assist Resident #44 the Speech Therapist stated, That was me I am trying to find some toilet paper.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 39043 Based on record review and staff interview, the facility failed to ensure residents were given the opportunity to make decisions regarding end-of-life care. This deficient practice had the potential to affect one (1) of four (4) residents reviewed for the care area of advance directives. Resident identifier: #59. Facility census: 77. Findings included: a) Resident #59 Review of Resident #59's medical records showed a Physician Orders for Scope of Treatment (POST) form completed by the resident's family member on 07/14/23. The POST form communicated the resident's wishes for end-of-life care. Further review of Resident #59's medical records showed a Physician Determination of Capacity form dated 08/28/24. The physician determined Resident #59 had the capacity to make his own health care decisions. On 09/25/24 at 9:55 AM, the Social Services Director stated when Resident #59 was admitted in August 2024, the resident's family member was his representative. The resident had a POST form that had previously been completed. The Social Services Director stated she had reviewed the POST form with Resident #59 upon his admission and he stated the POST form represented his wishes. However, the Social Services Director acknowledged the POST form had not been redone when Resident #59's physician determined the resident had the capacity to make his own medical decisions. No further information was provided through the completion of the survey.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview, the facility failed to provide proof the required Notification of Medicare Non-Coverage (NOMNC) liability and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) notices were issued in a timely fashion for one (1) of three (3) residents reviewed for beneficiary protection notification. NOMNC was improperly dated. This failure had the potential to place the resident at risk of not being informed of their appeal rights prior to the end of Medicare covered services as well as being informed of their rights prior to the end of Medicare Part A covered services . Resident identifier: #281. Facility census: 77. Findings included: a) Resident #281 On 09/25/24 05:35 PM, Review of Notice of Medicare Non-Coverage form for Resident # 281 revealed the resident's services were due to end/last covered day of Part A Services on 5/28/24. The resident's representative was notified telephonically on 03/23/24 at 10:03 AM by Office Manager #24. Observation of digital records for Resident #281 revealed that resident was admitted on [DATE]. On 09/26/24 at 1:26 PM, during an interview with Office Manager (OM)#24, the OM acknowledged the Notice of Medicare Non-Coverage for Resident #281 was dated for 03/23/24 in error and reported that it should have read 05/23/24.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49465 Based on observation, staff interview and resident interview, the facility failed to provide a safe, clean and comfortable home like environment. Resident #50 did not have a screen in his window. This failed practice was found true for (1) one of 12 residents reviewed for the environment during the Long-Term Care Survey Process. Resident identifier #50. Facility Census 77. Findings Included: a) Resident #50 During the initial interview on 09/23/24 at 1:38 PM, Resident #50 stated, I cannot open this window because there is not a screen in it. I have asked several times to get a screen but still do not have one. An observation on 09/23/24 at 1:38 PM, revealed that Resident #50 had four (4) windows in his room and the second window did not have a screen. On 09/24/24 at 3:30 PM, The Maintenance Director confirmed that the screen was not on the window and stated, I will get one in there as soon as I can.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 50551 Based on record review, resident interview and staff interview, the facility failed to prevent potential further abuse of all residents while investigating an allegation of resident-to-resident abuse and failed to complete a thorough investigation. Resident identifiers: #72 and Resident #31. Facility Census: 77. Findings included: a) Resident #72 09/24/24 9:00 AM During an interview with Resident #72, Resident denied having any conflict or issues with other residents in the recent months. He declined/was unable to discuss the incident. 09/26/24 at 8:30 AM, a review of the Five-Day Follow-up on an incident dated 05/13/24 Resident # 72 reported he was leaving bingo and was halfway out the door when Resident #31 hit him with his wheelchair. Resident #72 turned around and yelled at Resident #31 who started hitting Resident #72, knocking oxygen out of his nose and knocking glasses off his face. Resident #72 reacted by hitting Resident #31. The incident resulted in an abrasion to upper lip, with blood noted to Resident #72. Resident #72 denied pain or discomfort. The resident reported that this is not the first time Resident #31 had hit him with his wheelchair. He denied depression or anxiety afterwards. Interventions included separating the two residents. Therapy put Resident #31 in a stationary chair when in the dining room for meals and activities and were looking into purchasing a device to make his wheelchair slower. Both residents were assessed by nursing, the physician was notified and gave no new orders. Appropriate notifications were made. Resident #31 had a history of running into feet with his wheelchair. Change in Condition was completed. b) Resident #31 On 09/26/24, a review of progress note completed by Registered Nurse (RN) #18 on 5/13/2024 at 3:00 PM for Resident #31 revealed: Resident #31 had an altercation with Resident #72 in the dining room during bingo. Staff brought Resident #72 to this nurse with bleeding from an abrasion on his top lip. Staff who witnessed the event stated Resident #31 was the aggressor and was hitting Resident #72. The residents were separated. Staff stayed with Resident #31 (the aggressor) until he was calm. The physician was contacted with details of the incident. There were no new orders at this time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/26/24 at 10:00 AM, Interview with Social Worker (SW) regarding investigation of the incident. SW reported that both residents involved in the altercation were separated. She stated that Resident #31 was placed on (one on one) 1:1 while the investigation was completed. When asked if there was documentation of this she stated, I guess I don't have anything. SW reported that interventions included skin assessments of both residents and modifications to Resident #31's wheelchair to make it slower. She stated that no interviews or audits were completed with other residents to determine if anyone else was affected. She also reported that there were no interventions at that time to address Resident #31's behaviors.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31826 Based on record review and staff interview, the facility failed to ensure Resident #20's Minimum Data Set (MDS) was correct in the area of falls with injury. This was true for one (1) of 12 residents reviewed for the care area of accidents during the long-term care survey process. Resident identifier: #20. Facility census: 77. Findings included: a) Resident #20 On the first day of the survey 09/23/24 in the afternoon the facility matrix provided by the facility was reviewed and indicated Resident #20 had a fall with an injury. A review of Resident #20's medical record found the resident had a fall on 07/07/24 but had no injury. A review of Resident #20's MDS with an Assessment Reference Date (ARD) of 07/13/24 found section J1900 was coded to represent a fall without injury since the last MDS assessment and a Fall with injury since the last MDS Assessment. An interview with Registered Nurse #40 at 12:20 PM on 10/01/24 found the resident had only sustained one (1) fall since the last MDS assessment and she was not injured because of the fall. She indicated the fall with injury should not have been included on the MDS, and the MDS was inaccurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 31826 49465 Based on record review and staff interview, the facility failed to correctly identify diagnosis on a new Pre-admissions Screening and Resident Review (PASSAR). This failed practice was found true for (1) one of (2) two residents reviewed for PASSAR accuracy during the Long-Term Care Survey Process. Resident Identifier: #1. Facility Census 77. Findings Included: a) Resident #1 A record review on 09/23/24 at 3:30 PM, revealed that Resident #1 has a diagnosis that included Schizophrenia and Epilepsy. Further record review revealed that a new PASSAR was completed on 02/17/22 and did not include the diagnosis of Schizophrenia and Epilepsy. During an interview on 09/25/24 at 12:28 PM, the Social Worker (SW) stated, I must have missed that one. When I first started I had to do an audit of them all so I guess I missed that one. The SW confirmed that the diagnosis was not on the most current PASSAR.

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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. 49465 Based on observation, record review and staff interview, the facility failed to develop and/or implement care plans related to fall interventions and depression. This failed practice was found true for (1) one of (5) five residents reviewed for mood and behavior and (1) one of 12 residents reviewed for accidents. Resident identifiers #34 and #42. Facility Census: 77. Findings Included: a) Resident #34 A record review on 10/01/24 at 9:30 AM revealed that Resident #34 had a fall on 08/21/24. On 08/22/24 Resident #34 was complaining of pain where it was revealed that she had a right hip fracture. Further record review revealed a fall care plan that reads as follows: Focus: Resident has experienced falls and is at risk for further falls r/t cognitive loss, lack of safety awareness, history of fall with fracture. Goal: Resident will have no further falls with injury through next review. Interventions: Provide resident/patient with opportunities for choice Bed in low position Medication review as needed Non skid footwear as tolerated. Non skid strips in front of recliner. Non skid strips to right side of bed. Obtain laboratory test results and report abnormal results Assist resident/caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage resident to attend activities that maximize their full potential while An observation on 10/01/24 at 11:45 AM of Resident #34 revealed the resident was lying in bed and had on fuzzy socks that were not non-skid. During an interview on 10/01/24 at 11:45 AM Resident #34 stated, It doesn't matter to me what socks they put on. A sock is a sock. During an interview on 10/01/24 at 11:48 AM with Nurse Aide (NA) #43 stated, Those are not non-skid socks. I like to put those on her while she is in bed. b) Resident #42 A record review on 10/01/24 at 9:30 AM of Resident #42 diagnosis revealed a diagnosis of depression and is ordered 7.5 milligrams (mg) of Mirtazapine by mouth at bedtime. Further record review revealed that Resident #42 has no care plan for Depression. During an interview on 10/01/24 at 10:14 AM, the SW stated, I was not here when he first came. No, there is not a care plan for Depression.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39043 Based on resident interview, record review, and staff interview, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene. This deficient practice had the potential to affect one (1) of six (6) residents reviewed for the care area of activities of daily living. Resident identifier: #6. Facility census: 77. Findings included: a) Resident #6 During an interview on 09/23/24 at 1:47 PM, Resident #6 stated she did not receive twice weekly showers as scheduled. She stated she preferred showers to bed baths. Review of Resident #6's comprehensive care plan showed the resident required assistance for activities of daily living due to a fracture of the leg. The care plan stated the resident required substantial/maximal assistance for bathing. The facility's shower schedule showed the resident was scheduled to receive showers on evening shift on Tuesdays and Fridays. Review of Resident #6's showers for the past 30 days gave the following information: - On Tuesday, 08/27/24, the resident refused a shower, according to the nurses' notes. - On Friday, 08/30/24, the resident did not receive a shower. However, the resident did receive a shower the following day, on 08/31/24. - On Tuesday, 09/03/24, the resident received a shower, according to the Nurse Aide (NA) task documentation report. - On Friday, 09/06/24, the resident received a shower, according to the NA task documentation report. - On Tuesday, 09/10/24, the resident received a shower, according to the NA task documentation report. - On Friday, 09/13/24, the NA task documentation report showed the resident had a bed bath. There was no documentation the resident refused a shower. - On Tuesday, 09/17/24, the resident received a shower, according to the NA task documentation report. - On Friday, 09/20/24, the resident received a shower, according to the NA task documentation report. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On Tuesday, 09/24/24, the resident refused a shower, according to the nurses' notes. No shower refusals were documented on the NA task documentation report. On 09/25/24 at 11:40 AM, the Director of Nursing (DON) stated shower refusals should be documented in the nurses' notes and on the NA task documentation report. She was informed Resident #6 had not received a shower as scheduled on 09/13/24, and no shower refusal had been documented for the resident that day. She provided no further information through the completion of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on resident interview, observation, record review, and staff interview, the facility failed to provide pressure ulcer treatment in accordance with professional standards of care. This deficient practice had the potential to affect one (1) of one (1) resident reviewed for the care area of pressure ulcers. Resident Identifier: #34. Facility census: 77. Findings included: a) Resident #34 Review of Resident #34's medical records showed she had a history of MASD/IAD [moisture-associated skin damage/incontinence associated dermatitis] during her admission to the facility. Review of Resident #34's medical records showed the resident returned to the facility from the hospital on 08/26/24 after surgical repair of a fracture. The hospital discharge summary was in the resident's medical record file. Attached to the discharge summary was a nurse report form that stated, Skin condition: DTI [deep tissue injury] on buttocks foam dressing. On 09/26/24 at 10:08 AM Unit Manager #10 stated the nurse report form was the facility's form. She stated the form was completed by the facility when the hospital called the facility to give a report on the resident. Review of Resident #34's prior physician's orders showed the following order written on 08/29/24: MASD/IAD: Cleanse sacrum with skin cleanser (i.e. remedy no-rinse cleansing foam) and pat dry. Apply Z Guard paste every day and night shift for MASD/IAD for 14 days. The order continued through 09/11/24. On 09/11/24, Resident #34 was seen in the orthopedic clinic for follow-up. The orthopedic physician's note, located in the resident's chart, stated, Patient has the start of a bed sore right along her sacrum. She says that she has had them before. (The sacral area is located at the base of the spine.) The orthopedic physician's assessment plan contained the following: She is to mobilize to help with perineal care and to avoid further ulcerations of the buttock. Patient would like something to protect her skin from breakdown and I told her to ask the medical doctor at the facility for some type of A and D cream or something exiting oxide as possible. She is amenable to the plan. (Note typed as written.) Review of Resident #34's current physician's orders showed the following order written on 09/17/24: Greers [NAME] Cream, apply to right buttock topically every day and night shift for MASD, cleanse with soap and water, then apply Greers Goo. The resident also had a current order for treatment for a right heel wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24, Resident #34 was seen in the wound care clinic for her heel wound. The wound care clinic's physician's visit record for 09/24/24 was in the resident's medical file. The physician wrote on the wound care clinic visit record, Clean right heel and gluteal ulcer daily with betadine. Apply bacitracin, Mepilex border. A nurse's note written on 9/24/2024 at 10:02 AM stated, Resident returned to facility via [Emergency Medical Service]; skin check completed with no new issues observed; orders received to cleanse right heel with betadine, apply bacitracin and cover with Mepilex border; turn every 2 hours; float heels while in bed; [follow up appointment] MPOA [Medical Power of Attorney] notified. The resident's weekly skin and wound evaluations of the buttocks area showed the following assessments: - 08/28/24: MASD/IAD, left gluteal fold, lateral, present on admission, measuring 2.1 centimeters (cm) x 1.6 cm. (The gluteal fold is the horizontal skin crease that forms below the buttocks.) - 09/03/24: MASD/IAD, left gluteal fold, lateral, present on admission, measuring 2.3 cm x 1.2 cm, noted to be covered with 90% epithelial tissue and improving. - 09/10/24: MASD/IAD, left gluteal fold, lateral, present on admission, measuring 1.6 cm x 0.9 cm, noted to be covered with 100% epithelial tissue and stable. - 09/17/24: MASD/IAD, left gluteal fold, lateral, present on admission, measuring 3.7 cm x 4.5 cm, noted to be monitoring. - 09/25/24: MASD/IAD, left gluteal fold, lateral, present on admission, measuring 0.7 cm x 0.9 cm, noted to be improving. (Wound pictures taken this day are difficult to visualize, but have areas circled on the coccyx area and the left gluteal fold area.) The resident's comprehensive care plan contained the following focus, Resident at risk for skin breakdown and bruising related to: advanced age (greater than [AGE] years), poor safety awareness, Dx: DM2 [diabetes mellitus type II], CKD [chronic kidney disease], Hx. [history] of Venous stasis ulcers to bilateral lower legs. -Surgical Incision to Right Lateral Thigh -MASD/IAD Sacrum -Stage 2 Right Heel During an interview on 09/26/24 at 8:50 AM, Resident #34 stated her bottom hurt. She gave her consent to have the nurse surveyor observe her skin condition with a facility staff member in attendance. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/24 at 8:55 AM, Nurse Aide (NA) #55 entered Resident #34's room to answer the call light, which the resident had pulled because she wanted to get out of bed into the chair. NA #55 stated she would assist the nurse surveyor in observing the resident's skin condition. NA #55 loosened Resident #34's incontinence brief and the resident was able to roll herself over onto her side. The resident had a tan-colored adhesive dressing to her sacral/coccyx area. The dressing was wrinkled and loose at the bottom of the dressing. No date could be seen on the dressing. NA #55 removed the wrinkled adhesive dressing and stated she would get a nurse to replace the dressing before the resident got up into a chair. The resident had a small open area under the dressing. Resident #34 also had a small open area to the left gluteal fold On 09/26/24 at 9:00 AM, Licensed Practical Nurse (LPN) #52 entered the resident's room. She asked the resident if she was having pain. When the resident replied her bottom hurt, LPN #52 stated she would get pain medication for the resident. She stated she would have to check the resident's dressing orders to be able to answer questions about the treatment. On 09/26/24 at 9:07 AM, LPN #52 completed a change in condition evaluation, which reported the resident had pain in the sacral area and redness and excoriation to the coccyx. The resident was ordered Tylenol 325 mg now, followed by Tylenol 325 mg three (3) times a day. On 09/26/24 at 9:10 AM, LPN #52 confirmed Resident #34's treatment was Greers Goo. She stated she did not know when the adhesive dressing had been placed on the resident's coccyx. She stated she has not been assigned to the resident very often and could not answer questions about how the resident's coccyx and buttocks had looked previously. New orders were entered on 09/26/24 to Cleanse gluteal wound with betadine, apply bacitracin, cover with Mepilex [sic] border dressing. Change daily and as needed if dressing becomes dislodged and for Greers goo to right and left buttock daily for MASD/IAD. A nursing note written on 09/26/24 at 5:54 PM stated, Change in condition completed this AM for resident complaints of pain in sacral/coccyx area. Upon assessment resident noted to have an unstageable pressure ulcer. See swift for measurements. Physician was notified. Residents HCS [health care surrogate], [name redacted] was notified. Educated on treatment orders. Understanding verbalized. Resident stated during this assessment that pain was much better. Resident has cushion noted in her wheelchair. Care plan reviewed and updated as needed. Dietician notified. A skin and wound assessment performed on 09/26/24 documented a pressure ulcer to the coccyx, unstageable due to slough, measuring 1 cm x 0.8 cm. During an interview on 09/30/24 at 11:47 AM, the Director of Nursing (DON) confirmed Resident #34's buttock and coccyx area had not been formally assessed from 09/10/24 until 09/17/24 although the resident's 14-day treatment had been completed 09/11/24. The DON also stated when the resident returned from the wound care clinic, the nurse had followed the physician's recommendation to cleanse the area and apply a bordered dressing but had not entered an order for this treatment. No further information was provided through the completion of the survey.

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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. 39043 Based on observation, record review, resident interview 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 #12 had a bottle of vitamins at her bedside, which had the potential to affect more than a limited number of residents. This was a random opportunity for discovery. Additionally, Resident #34 did not have non-slip socks on at the time of a fall. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of falls. Resident identifiers: #12, #34. Facility census: 77. Findings included: a) Resident #12 On 09/25/24 at 8:45 AM, Licensed Practical Nurse (LPN) #52 was observed administering medications to Resident #12. When LPN #52 took the resident's medications into the room, Resident #12 took a bottle of Centrum Women's vitamins off her overbed table, stating I don't like the vitamins that the facility has. She opened the bottle and appeared to be ready to take a vitamin. The vitamin bottle appeared to be at least half full of pills. LPN #52 told the resident that she would have to take the vitamins from the bedside and get a physician's order for them. The resident stated, I was told I could have them but agreed to have the nurse take the bottle away from the bedside. The vitamins posed a risk to wandering residents who may have entered the resident's room and taken the vitamins. Per the website WebMD, symptoms of Centrum Women's vitamins overdose may include stomach pain, nausea, vomiting, and diarrhea. On 09/25/24 at 8:50 AM, LPN #52 stated that residents should not have medications at their bedside. She stated she would contact the physician to obtain an order for the vitamins. b) Resident #34 A record review on 10/01/24 at 9:30 AM revealed that Resident #34 had a fall on 08/21/24. On 08/22/24 Resident #34 was complaining of pain where it was revealed that she had a right hip fracture. Further record review revealed a fall care plan that reads as follows: Focus: Resident has experienced falls and is at risk for further falls r/t cognitive loss, lack of safety awareness, history of fall with fracture. Goal: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident will have no further falls with injury through next review Interventions: Provide resident/patient with opportunities for choice Bed in low position Medication review as needed Non skid footwear as tolerated. Non skid strips in front of recliner. Non skid strips to right side of bed. Obtain laboratory test results and report abnormal results Assist resident/caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement. Encourage resident to attend activities that maximize their full potential while. Further record review revealed a incident report that reads as follows dated 08/21/24: Resident observed to be laying in floor on right side, stated, I wanted to lay in floor Assessed resident for injury with none observed, denies pain at this time. Resident not wearing non skid socks at this time. Room arranged in typical manner with adequate temperature. Resident continent of bowel and bladder. Notified provider and Medical Power of Attorney (MPOA). Initiated neuros. Further record review revealed a Change in Condition form dated 08/22/24 that Resident # 34 has a right hip fracture. An observation on 10/01/24 AT 11:45 AM, of Resident #34 revealed the resident was lying in bed and had on fuzzy socks that were not non-skid. 49465

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 31826 39043 Based on observation, resident interview, record review, and staff interview, the facility failed to provide hydration care and services to each resident, consistent with the resident's comprehensive assessment and their needs and preferences. This deficient practice had the potential to affect three (3) of 13 residents reviewed for the care area of hydration. Resident identifiers: #68, #59, and #180. Facility census: 77. Findings included: a) Policy review The facility's polity titled Nutrition/Hydration Care and Services with effective date 01/01/04 and revision date 02/01/23 stated to keep beverages available and within reach, when applicable. b) Resident #68 During an interview on 09/23/24 at 11:47 AM, Resident #68 was asked if he received enough to eat and drink. Resident replied that he received very little water. He had no cups or beverage containers in his room. On 09/26/24 at 10:00 AM, Resident #68 was observed to have a cup of water at his bedside. However, the water did not have ice in it and the cup was not cool to the touch. The resident's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 07/12/24 showed the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. The resident's comprehensive care plan had the following focus initiated 11/21/23: Resident exhibits or is at risk for dehydration r/t [related to] diuretic use. Review of the resident's physician's orders showed the resident was receiving the diuretic Lasix 20 mg every day for Congestive Heart Failure (CHF). On 11/22/23, the Registered Dietician assessed the resident's fluid intake needs as 1975 cc per day. c) Resident #59 During an interview on 09/23/24 at 2:30 PM, Resident #59 was asked if he gets enough to eat or drink. He stated he had to ask for water when he wanted some. He was noted to have a plastic pitcher on bedside table with nothing in it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/24/24 at 11:24 AM, Resident #59 again had an empty plastic pitcher on his bedside table. The resident stated he would like to have some water and ice. NA #12 verified the resident's pitcher was empty. She asked the resident if it was okay if she brought him a Styrofoam cup with water and ice. The resident agreed, and NA #12 brought him some ice water. On 09/26/24 at 10:00 AM, Resident #59 was noted to have two (2) small cups of water at his bedside. However, the water did not have ice in it and the cup was not cool to the touch. The resident's admission MDS assessment with ARD 08/27/24 showed the resident's BIMS score was 11, indicating the resident had mild cognitive impairment. The resident's comprehensive care plan had the following focus: Resident exhibits or is at risk for dehydration AEB (as evidenced by) constipation. On 08/28/24, the Registered Dietician assessed the resident's fluid intake needs as 1875 cc per day. NA task reports indicated the resident was receiving adequate fluid intake. NA task reports also indicated the resident had a bowel movement almost every day. d) Resident #180 During an interview on 09/23/24 at 2:55 PM, Resident #180 was asked if he had any problems with the care he received at the facility. The resident replied he once asked for water and had to wait two (2) hours to receive it. The resident currently had water in a plastic pitcher. The resident stated he had water because he asked for it earlier. On 09/26/24 at 10:00 AM, Resident #180 was noted to have a Styrofoam cup of water at his bedside. However, the water did not have ice in it and the cup was not cool to the touch. The resident was a new admission and did not have a BIMS score recorded. However, he answered questions appropriately. The resident's comprehensive care plan contained the following focus initiated on 09/19/24, Resident exhibits or is at risk for dehydration r/t [related to] diuretic use. NA task reports indicated the resident was receiving adequate fluid intake. On 09/26/24 at 10:30 AM, NA #48 stated she usually gives residents water and ice between breakfast and lunch and then again between lunch and dinner. She stated the night shift also gives the residents water and ice. NA #48 stated she was getting ready to give the residents water and ice for the morning.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50551 Based on record review and staff interview, the facility failed to proved sufficient nurse staffing numbers. This had the potential to affect all residents. Facility census: 77. Findings included: a) Resident Interviews During an interview on 09/23/24 at 03:50 PM, resident #39 reported that staff would turn off her call light and tell her they would be right back to assist her and she has had to wait 2 hours for them to come back. On 09/24/24 at 08:38 AM, an interview with resident #7 who reported that she had to wait from 4:30 PM to 7:30 PM and at dinner time she had to wait to get her brief changed due to low staff numbers. On 09/24/24 at 08:57 AM, during an interview with resident #72 who reported that he usually had to wait half an hour for his call light to be answered due to low staffing. b) record review On 10/01/24 at 3:00 PM, review of the Daily Nurse Staffing Form for the following days, revealed that there was not sufficient staffing for the following days: 09/15/24- 2.01 Census 75 Nursing Hours 150 09/28/24- 2.06 Census 80 Nursing Hours 165.50 09/29/24- 2.1 Census 80 Nursing Hours 168 c) staff interviews On 09/23/24 at 11:24 AM, an interview with Nurse Aide #4 reported that there are sometimes 2 (two) aides during the day and one at night and this is not enough staff to meet the needs of the residents. Sometimes the facility will pull a restorative aide to assist but she is not able to assist the entire twelve hour shift. On 10/01/24 at 3:48 PM, an interview was conducted with Scheduling and Payroll Manager #15 who reported that staffing has been horrible, no staffing and no one to call in. She reported that she had been attempting to hire 3 (three) Nurse Aides but it is a three week process. She reported that she had recently had staff quit or go back to school causing a shortage. She acknowledged that the facility did not have sufficient staffing on the following days: 09/15/24- 2.01 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	09/28/24- 2.06 09/29/24- 2.1

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50551 Based on record review and staff interview, the facility failed to ensure a Registered Nurse was available 8 consecutive hours a day, 7 days a week. This had the potential to affect all residents at the facility. Facility census: 77. Findings included: a) A review of the facility staff postings revealed that on 09/14/24 and 09/28/24 no Registered Nurse (RN) was scheduled to work on the above dates. A review of timecards for all staff working on 11/19/23 and 12/03/24 found no RN coverage. On 09/15/24 and 09/22/24 there was RN coverage reported but no proof on time card, notes, medication administration that there was RN coverage on those days. b) On 10/01/24 at 3:48 PM, an interview with Scheduling and Payroll Manager #15 was conducted. She acknowledged that she had no documentation made by RN scheduled to be on duty for dates and no RN on listed on the schedule for dates 09/15/24 and 09/22/24 in which RN coverage was reported. She also acknowledged that there was no RN coverage reported for 09/14/24 and 09/28/24.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31826 Based on resident interview, staff interview, and test tray temperature measurements, the facility failed to serve food that was palatable and at an appetizing temperature. This failed practice has the potential to affect more than a limited number of residents. Facility Census: 77. Findings Included: a) Resident Interviews During an interview with Resident #68 on 09/23/24 at 11:41 AM he stated the food is always cold and is not good. He stated, he does not like rice, and he gets it at least three (3) times a week. During an interview with Resident #15 on 09/23/24 at 12:00 PM he reported he often orders cheeseburgers from the kitchen because the food does not have a good taste. During an interview with Resident #180 on 09/23/24 at 2:57 PM the resident stated the food is tasteless and it is always cold when it gets to his room. b) Test Tray On 09/25/24 at 1:00 PM the Certified Dietary Manager was asked to take the temperatures on a test tray immediately after the last resident tray was served. The temperatures were as follows: -- Tuna Melt 112 degrees Fahrenheit. -- Potato Wedges 85 degrees Fahrenheit. The Certified Dietary Manager stated, they should be hotter than that, but this meal is hard to keep warm.

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 31826 Based on record review, observation, and staff interview, the facility failed to ensure Resident #21 received liquid at the appropriate thickness as ordered by the physician. Resident #21 would have been given regular consistency tea had the surveyor not intervened. Resident #21 physician's orders indicated she should only receive pudding/spoon thickened liquids. The State Agency (SA) found this failure rose to the level of an Immediate Jeopardy (IJ). The Nursing Home Administrator (NHA) and Director of Nursing (DON) was notified of the IJ on 09/25/24 at 3:45 PM. The SA accepted the plan of Correction (POC) at 6:40 PM on 09/25/24. After verification of the steps of the POC being Implemented the IJ was abated at 3:15 PM on 09/26/24. This failed practice was true for Resident #21 but had the potential to affect any resident receiving thickened liquids. At the time of the discovery only Resident #20 and Resident #75 received thickened liquids. Resident identifiers: #21. Facility Census: 77. Findings Included: a) Resident #21 A review of Resident #21's medical record found an order for spoon thick liquids. The order was put in place on 06/04/24. An observation of Resident #21's door found a circular sticker with the letter P on it to indicate the resident should receive Pudding Thickened liquids. The meaning of this sticker was confirmed with the Director of Nursing (DON) on 09/25/24 at 2:12 PM. Pudding and spoon thick liquids are interchangeable and refer to drinks which are pudding thick consistency. A review of the resident's speech therapist (ST) notes found the following, Summary of skilled interventions Provided: Patient has been seen for ST skilled services for dysphasia treatment for assessment of swallow function in order to determine safest diet level, decrease risk of aspiration, and educate staff on patient's diet level and risk of aspiration. Patient is consuming a puree diet level with pudding thick liquids. Education with return demonstration completed with staff to ensure accuracy and understanding of the patient's new liquid level, especially because it is not readily utilized in this facility. Patient continues to have occasional episodes of overt signs and symptoms of aspiration, despite the modifications. ST plans to discontinue services on 06/21/24 pending no further changes in function. A review of the resident's care plan found the following goal and interventions, Focus Statement: (First Name of Resident #21 First Name) is at nutritional risk related to Huntington's Disease which increases energy expenditure, Dysphasia with mechanically altered diet in place, Hypokalemia, and Significant Weight Loss. (continued on next page)

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goals: Resident will maintain weight and have no undesirable weight loss thru next review Interventions included: -- Regular/Liberalized Diet with Puree Texture and Thickened Liquids-Spoon Thick Consistency. Plastic silverware per order. This intervention was last revised on the care plan on 06/07/24. An observation on 09/25/24 at 1:05 PM found Licensed Practical Nurse (LPN) #47 was assisting Resident #21 with her lunch meal. LPN #47 stated, Would you like another drink? At which time she picked up Resident #21's drink which was sweet tea. When she picked up the drink it was obvious to the surveyor the tea was regular/thin. LPN #47 placed the cup to the resident's lips to give her a drink. The surveyor at this time intervened and stated, Please don't give her that. The LPN said, 'Why not. The surveyor stated, She is supposed to have pudding thickened liquids. LPN #47 sat her drink down and continued to feed the resident her meal. At the conclusion of the meal she cleared the tray and left the tea on the bedside table. She stated, I am going to get some thickener for that in case you are wondering. All the other items on the resident's tray were correct because they had come from the kitchen. Staff on the floor are responsible for all drinks served at meals. The kitchen does not send thickened drinks on the resident's tray. About five (5) minutes later LPN #47 returned with a bowl with some thickener in it. LPN #47 poured in a small amount of thickener and stirred the tea. The tea was still not pudding thick and could have easily been poured from the cup. She again placed the cup to the resident's lips to give her a drink. LPN #47 was asked, How do you know if it is the right consistency? She looked at the cup and put the spoon in and out of the tea a few times and stated, Is that not thick enough. The surveyor then stated she was on pudding thickened liquids, and no it was not thick enough. The LPN then abruptly poured in some more thickener from the bowl. She then stirred it up. The surveyor stated, If you're not sure you can ask someone. She looked at the liquid again and said, Well it looks like pudding to me, and proceeded to feed the resident the thickened tea. During an interview with the Director of Nursing (DON) on 09/25/24 at 2:12 PM the DON was asked how they determine something is proper consistency when the kitchen provides a bowl of unmeasured thickener opposed to the packet of thickener which tells you how many packets to use for each thickness. The DON stated, They just look at it and add it until it looks right. She made no mention of measuring the appropriate amount as directed by the manufacturer. After the notification of the IJ the facility obtained an order for a chest X-ray for Resident #21. This order was obtained on 09/25/24 at 3:51 PM. The results of the X-ray were reviewed by the surveyor in the afternoon of 10/01/24. The results read as follows: Examination demonstrates no mediastinal shift. There is left lower lobe atelectasis, but no acute alveolar/interstitial infiltrate, consolidation, CHF, Mass or pneumothorax b) Facility Plan of Correction (continued on next page)

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's accepted plan of correction read as follows, The licensed nurse conducted an evaluation on 9/25/24 with notification to the medical provider of the possible risk of aspiration for Resident #21. The Speech therapist provided education to the Director of Nursing (DON) on 9/25/24 regarding the process to mix thicken liquids per the manufacturer guidelines. The Director of Nursing (DON)/designee provided education to Licensed Nurse #47 on 9/25/24 regarding the process to mix thicken liquids per the manufacturer guidelines. All residents of the facility have the potential to be affected. The Director of Nursing (DON)/designee conducted an observation round on 9/25/24 to ensure residents receiving thickened liquids are mixed according to manufacturer's guidelines with any corrective action immediately upon discovery. Reeducation will be provided by the Director of Nurses(DON)/designee to nursing staff on 9/25/24 regarding residents receiving thickened liquids mixed according to manufacturer's guidelines with a posttest and return demonstration (per the attachment educational document) to validate understanding. Any nursing staff not available during this time frame will be provided reeducation, including posttest and returned demonstration by DON/designee prior to the beginning of their shift. New nursing staff will be provided education and return demonstration, including posttest during orientation by the DON/designee. Reeducation will be provided by the Dietary Manager (DM)/designee to dietary employees on 9/25/24 regarding not to send out thickening powder during meal service with a posttest to validate understanding. Any dietary staff not available during this time frame will be provided reeducation, including posttest by DM/designee prior to the beginning of their shift. New dietary employees will be provided education, including posttest during orientation by the DON/designee. The Unit Manager/designee will monitor during meal service starting on 9/25/24 for dinner to ensure residents receiving thickened liquids are mixed according to manufacturer's guidelines daily across all meal service for 2 weeks, including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then randomly thereafter. The Unit Manager/designee will monitor during meal service starting on 9/25/24 for dinner to ensure dietary does not send out thickening powder during meal service daily across all meal service for 2 weeks, including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then randomly thereafter. Results of monitors will be reported by the Director of Nursing (DON)/designee to the Quality Improvement Committee (QIC) monthly for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the Quality Improvement Committee. On 09/26/24 the education posttests were reviewed for all staff who had worked since the notification of the IJ with no issues identified. (continued on next page)

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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 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse Aide #55 was observed assisting Resident #21 her noontime meal. She correctly thickened her drink and upon interview was able to describe the education she received and answered all questions appropriately. NA #18 was also interviewed and was able to answer all questions appropriately related to thickening the resident drinks. LPN #52 was interviewed and was able to describe her education and was able to provide details into how to thicken resident drinks. After implementation of the POC was completed the IJ was abated at 3:15 PM on 09/26/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 31826 Based on observation and staff interview, the facility failed to ensure food was served in a safe and sanitary manner. This was a random opportunity for discovery and had the potential to affect more than an limited number of residents. Facility Census: 77. Findings Included: a) Tray Line Observation An observation of the meal service for the noon time meal on 09/25/24 beginning at 11:30 am found the following, Resident #52 was served Salisbury steak covered in gravy from the kitchen. The meal went directly from the kitchen to the dining room and was served to the resident. After it was served [NAME] #69 obtained a thermometer to obtain the temperature of the gravy which had been sitting on the stove cooling. The temperature was 122 degree Fahrenheit (F). The cook stated, I need to reheat this and turned on the stove to reheat the gravy. The cook was then asked if the gravy which he just served was from that pot and he said, Yes it was. He reheated the gravy to 150 degrees F and then began serving it again. When asked what the gravy needed to be reheated to he stated, 135 degrees F. An interview with the Certified Dietary Manager (CDM) on 09/25/24 at 1:02 PM found the gravy should have been reheated to 165 degrees F. She was informed the cook only reheated it to 150 degrees before he began serving it again and she stated she would do education with him. 49465 b) Alzheimr's Unit During the initial observation of the noon time meal on 09/23/24 in the Alzheimer's unit it was found that several staff were serving meal trays to residents seated in the dining room. Staff put on gloves to serve the residents, but never changed their gloves for the entire meal pass process. During an interview on 09/23/24 at 12:01 PM, Nurse Aide (NA) #11 stated, This is how we always do it. We change them if we have to feed a resident

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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. 31826 Based on record review, observation, and staff interview, the facility failed to ensure Resident #20's medical record was complete and accurate. This was true for one (1) of 31 sampled residents reviewed during the long-term care survey process. Resident Identifier: #20. Facility Census: 77. Finding Include: a) Resident #20 On 10/01/24 at approximately 10:15 AM Resident #20 was observed sitting in the tv lounge with her 10:00 AM supplement sitting in front of her. The supplement was still three quarters of the way full. A review of Resident #20's medical record at 10:25 am on 10/01/24 found the nurse had documented Resident #20 had consumed 100 percent of her house supplement. The surveyor returned to the TV lounge and Resident #20 still had her house supplement sitting in front of her on the table. It was still three fourths of the way full. An interview with Licensed Practical Nurse (LPN) #52 was interviewed at 10:31 AM on 10/01/24. She was asked if Resident #20 had consumed her 10:00 AM supplement. She pulled up the residents' medication administration record (MAR) and confirmed it was marked to indicate the resident had consumed 100 percent of her supplement. When asked if the pink drink on the table in front of Resident #20 was her house supplement LPN #52 stated it was and she would ensure she drank it. She agreed she had documented she had consumed 100 percent of her supplement before the resident drank all the supplement. A review of the Medication Administration Audit report for 10/01/24 confirmed LPN #52 documented the resident had consumed 100 percent of her supplement at 10:23 AM.

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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. 39043 Based on observation, medical website review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. The facility stored items under a sink area, which had the potential to affect more than a limited number of residents. Additionally, Resident #13's urinal was on the overbed table while he was eating. These were random opportunities for discovery. Resident identifier: #13. Facility census: 77. Findings included: a) Medication Preparation Room On 09/25/24 at 10:42 AM, the medication storage room in the memory unit was inspected with Licensed Practical Nurse (LPN) #42 in attendance. Under the sink were three (3) BinaxNOW boxes containing COVID-19 testing and a bag containing tools. On top of the bag containing tools were a pile of clothes. LPN #42 stated the clothes were probably extra clothes for residents who might need them. She stated she didn't know they were there. LPN #42 stated she would have them washed and stored in another area. She also stated she would remove the COVID-19 testing and discard them. According to the John Hopkins Medicine Health, Safety, and Environment Website, The area under a sink should be considered a soiled environment. Therefore, anything that a patient or staff member wears, ingests, or is treated with should not be stored under a sink. Additionally, the Center for Disease Control Sterilizing Practice Website stated, Medical and surgical supplies should not be stored under sinks or in other locations where they can become wet. No further information was provided through the completion of the survey. 31826 b)) Resident #13 An observation of the noon time meal service on 09/24/24 found at 12:15 pm the Medical Records Manager delivered Resident # 13's lunch tray. She sat his tray on his bedside table beside his urinal which was a quarter of the way full with urine. The resident was observed eating his meal while the urinal remained on his table. At 12:20 pm the Nursing Home Administrator (NHA) was advised of the above findings she went into the room to remove the urinal she was heard asking Resident #13 if she could move the urinal and then she exited the room to obtain a glove. During the time she was out of the room Resident #13 was observed holding the urinal with one hand and eating with the other hand. The NHA then reentered the room and retrieved the urinal from Residen