STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E148	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153 Based on observation, staff interviews, medical record review, temperature log review, and facility reportable incident (FRI) review, and hospital record review the facility neglected to ensure one (1) of six (6) residents was not subjected to hot water temperatures of 134 degrees Fahrenheit (F). This failure resulted in physical harm to Resident #19. Resident #19 sustained second degree burns to left hand, bilateral lower extremities and feet, bilateral buttocks and scrotum. This created an immediate jeopardy situation that began on 01/04/24 at 7:12 PM when the resident was placed in the tub and ended on 01/07/24 at 6:54 PM when all hot water was shut off in the facility. All residents had the potential to be affected by the hot water temperatures. Resident identifier: #19. Facility census: 44. Findings included: a) Facility Reportable Incident (FRI) A facility reported incident was received at the state agency on 01/04/24. The report stated Nurse Aide (NA) #99 put Resident #19 into a whirlpool tub. She filled the tub to the knee level. The nurse aide realized the water was too warm. She had another aide try to adjust the water. The nurse aide admitted to not looking at the water temperature and this resulted in Resident #19 receiving severe burns to lower legs, feet, thighs, and left hand. The facility reported the immediate action taken was to suspend the nurse aide, take all tubs out of service and check for malfunction. Adult protective services were notified, as well as, the ombudsman, the local sheriff's department, and the nurse aide registry. A second facility reported incident dated 01/04/24 related to Resident #19 was also received by the state agency. This incident stated the registered nurse did not assess or treat a resident with severe burns timely. The immediate action taken was a suspension of the registered nurse in addition to the nurse aide and a shutdown of the bathtubs. A third facility reported incident dated 01/04/24 was sent to the state agency. This incident stated Maintenance Supervisor (MS) #76 had been monitoring water temperatures for over six (6) months which did not meet regulatory guidelines. MS #76 failed to report the temperatures or attempt to make any changes to meet regulatory compliance. The report revealed MS #76 said he was aware of the guidelines for water temperature and chose to keep it warmer per staff request. (continued on next page)

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The five (5) day follow up report obtained on 01/09/24 revealed the following: After reviewing camera and interviewing staff (Registered Nurse #100) was asked by CNA (certified nurse assistant) that was giving (Resident #19) his bath to assess him. Another CNA asked nurse to assess him. Finally at 7:36 she went to shower room and left at 7:37. At 8:44 she got order to send to ER (emergency room). No 1st aide administered by unit nurse until 9:05. Nurse (Registered Nurse #100) sent home until investigation over. (Registered Nurse #100) failed to assess (Resident #19) when asked 3 times by CNAs. Did not administer treatment in a timely manner. I find this report to be substantiated for neglect of resident. (Registered Nurse #100) will be removed from schedule and her agency will be notified of decision. Excessive delay in treatment. This report was completed by social service supervisor. A five day follow up to the immediate report for Certified Nurse Aide (NA) #41 revealed: After reviewing camera and interviewing NA #41 who was called to shower room and found the water too hot and adjusted water temperature. She was seen on camera leaving the shower room and going to nurses station but camera has no sound. I find this to be substantiated. NA #41 did adjust water but failed to assist in maintaining safety of resident. NA #41 sent home until investigation is done. I find this report to be substantiated for neglect of resident. NA #41 will be removed from schedule and her agency will be notified of decision. This report was completed by the social service supervisor. b) Facility Entrance During the entrance conference with the Assistant Nursing Home Administrator (ANHA) and the DON, on 01/09/24 at 12:25 PM, the DON stated Resident (#19) had received third degree burns to both lower extremities during a tub bath on the evening of 01/04/24. Resident #19 had been transferred to a local hospital and then transferred to an out of state burn unit. c) Resident #19 Resident #19 was admitted to the facility 10/12/17. Medical diagnoses included dementia with behavioral disturbances, unspecified psychosis not due to a substance or known physiological condition, peripheral vascular disease (PVD), alcohol dependence in remission, Fabry's disease, and high blood pressure. No Brief Interview for Mental Status (BIMS) was able to be obtained as the only verbal response was grunting. The resident was incontinent of bowel and bladder and required total care. The state of [NAME] Virginia served as health care surrogate for this resident. d) Timeline A timeline provided by the facility revealed Resident #19 was taken to the tub room on 01/04/24 at 7:12 PM by Nurse Aide (NA) #99. The following information is a review of the videotape of the hallway activity conducted by the Social Worker (SW) and the Minimum Data Set (MDS) Coordinator. This video was on 01/04/24 and reviewed on 01/05/24. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7:12 PM Resident #19 was taken to the tub room by Nurse Aide (NA) #99. 7:16 PM NA #99 out in the hall times two (2) and back to the tub room. 7:17 PM NA #99 out of the tub room-went to Resident #19's room and returned to the tub room. 7:20 PM NA #99 to Nurses Station (NS) then part way up hall got NA #41 and together they went to the tub room. 7:21 PM NA #41 leaves the tub room and goes to the NS back to the tub room and back to NS. 7:23 PM NA #41 in NS and leaves the NS at 7:24 PM. 7:26 PM NA #41 in the tub room then to NS at 7:27 PM. 7:29 PM NA #99 out in the hall to the linen cart and returns to the tub room. 7:33 PM NA #99 to NS and appears to be returning to the tub room. NA #99 gets NA #59 who is coming down the hall and they both go to the tub room together at 7:34. 7:35 PM NA #59 to NS. 7:36 PM NA #59 and RN #100 to tub room 7:36 PM NA #41 at NS 7:37 PM RN #100 returns to NS 7:52 PM NA #99 to NS and back to tub room 7:54 PM NA #99 to NS and back to tub room 8:00 PM RN #100 to tub room 8:02 PM RN #100 to NS 8:04 PM NA #63 arrives from Unit A1 to assist. 8:08 PM NA #41 leaves NS and goes to the tub room. 8:12 PM Resident #19 is taken back to his room. 8:15 PM NA #59 to NS and back to Resident #19's room 8:22 PM NA #41 to NS and then back to Resident #19's room 8:25 PM NA #63 leaves Resident #19's room, goes to the linen cart and returns to Resident #19's room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8:28 PM NA #63 leaves Resident #19's room and returns with more linens. 8:33 PM NA #63 leaves Resident #19's room and returns with more linens. 8:38 PM NA #63 to NS and then to tub room 8:40 PM NA #59 to the tub room and then NS 8:41 PM NA #63 and #59 return to Resident #19's room. 8:42 PM NA #59 goes down B1 hall then returns to Resident #19's room. 8:43 PM NHA (nursing home administrator) on the unit and immediately goes to the tub room then NS and then to Resident #19's room. A review of a nursing progress note by RN #100 revealed the resident was transferred on 01/04/24 at 9:15 PM to the local hospital. Resident #19 was documented to have blistering and peeling skin to bilateral feet and calves. Vitals were documented from three (3) hours prior to transfer: Temperature: 97.7 (36.5 C) (01/04/2024 17:53 (5:53 PM) Pulse 55 (01/04/2024 17:53 (5:53 PM) Respiration: 18 (01/04/2024 17:53 (5:53 PM) Blood Pressure: 127/66 (01/04/2024 17:53 (5:53 PM) e) Investigation Statements -HSW (health service worker) #99 Statement dated 01/04/24 as follows: I was giving resident B110b (#19) a bath, as the last bit of water was draining out I noticed he had a blister on the back of his foot. I then went to the nurses station to tell the nurse (RN #100). she said she would come look at it shortly. I waited a few minutes and noticed more blisters were showing up so I went to get the other aide on the hall (name of aide) (HSW #59). She looked at it and also went to tell the nurse she needs to come look at it now. The nurse came to look at it and said she'd call the on call nurse to see what to do next. (see whether he'd need to be sent out or not.) HSW #99, #59 and #63 (identifiers used instead of names) transferred him to his wheelchair after letting some time go by to see what the nurse wanted us to do, then took him to his room, got him in bed, and laid cold compresses on his feet and legs to stop further blistering. Typed as written. -HSW #41 Statement dated 01/04/24 as follows: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	I am floating unit to unit. I came over to B. As I was walking down the unit HSW #99 waved me down and asked me to lower the water temp. I walked in and put my hand in the water and said that's hot. the [sic] looked at the temp gauge and it was 134. The water was past his knees but not running. I immediately turned the temp down and ran cold water in the bath. It cooled down and went out of the bath back to my task I was doing. Then when I walked back up the hall. I overheard he had blisters and recalled what happened. 1/4/24 9:01 pm I knew the bathtub would go to 140 but I didn't report it because the other staff told me it was normal and how to fix it. Typed as written. -HSW #59 Statement (first name of HSW #59) came to get me to see if I could get the nurse to look at Resident #19 because she thought his feet looked bad and the nurse to her she would look at them when he got back into bed. So I went to the tub room to look at them and seen they were badly blistered on the top and sides and a blister on his shin (left). After I seen them I went to the nurses station to tell the nurse she needed to come look at him. She said Why do they look bad? I told her no you want to come now. The nurse finally came into the tub room to see his feet when she saw the she asked if Resident #19 had edema? I told her yes, but that ' not the problem. The nurse then said she will go check the computer to see if day shift reported it. I told her it was from the water and those were burns because it looked like his skin was melting off. Resident #19 was left in the empty tub for awhile after and I decided he needed to be moved to his room via w/c (wheel chair) because he was ripping his skin off his legs by rubbing them together and ripping the skin off his feet by rubbing them on the drain. We put him to be and placed wet rags on his burns and stayed with him trying to keep him comfortable waiting to see what was going to happen. Stayed with him until EMS came. Signed by HSW #59 with date of 01/05/24. -Nursing Home Administrator (NHA) statement on 01/09/24 at 10:04 AM. I arrived at Hopemont once being made aware of this issue of the burn. I went to the resident floor. Nurse (last name) RN #100 was at the nurses station. She said to me (Resident first name) #19 is in his room. I went to his room and CNA staff advised they repeatedly told (RN first name) RN #100 that resident (resident first name) #19 was burned and she needed to look at him. They said she only momentarily observed him while in the tub and left the bathroom. They got him out of the tub and took him to his room. I observed Resident #19 and stated he is in obvious discomfort and pain that needs to be addressed. They stated the nurse never came to his room. My involvement and goal was to see that appropriate steps regarding addressing this issue were implemented to identify, correct, process, and investigate the matter fully and thoroughly. I went to the nurses station after watching the resident writhing in pain. I advised RN #100 he needs pain management now. I asked if she had been to his room. She said no and asked if she should call the doctor. I told her something needs to be done now. Further I learned that the doctor ordered the resident sent out and that it was almost 30 minutes before RN #100 even called 911. She in no way assessed the resident and his care needs. I helped interview her with the social worker. She excused her action on training and orientation. I explained as a long term RN and having worked here before she was well aware of the process, care responsibility, appropriate reaction to resident need and that emergency care is immediate paperwork second. She was removed from the schedule -RN #100 Statement (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This nurse was at nurses desk when first CNA came out to desk from shower room and asked if resident's (Resident #19) feet normally peel. Told CNA I would check on it. Other CNA approached several minutes later and asked nurse to come and assess residents feet. This nurse went to assess feet. Lower part of legs about 1 inch red and feet were red, blistering and starting to peel. Attempted to contact A! to get phone numbers to try and contact on call. There was no answer. Attempted to message on call but reply not immediate. Got on call number from another staff and (unable to determine this word). Informed of situation. On call supposed to re-contact. Contacted MD for order to send out after second assessment with blisters large and redness moving up his legs. Delay in call back from on call. MD gave permission to send out. Contacted back by phone and several minutes later contacted by ADON. Started process to send out. Called 911 and gave report. Contacted MD back as ADON arrived and went to see resident to get order for pain med. Paper work put together and EMS arrived after giving pain med. Signed by RN #100. There was no date nor times when this statement was to when it was written and no times when calls were made or resident assessments completed. A review of of nursing progress notes titled Nursing transfer/Discharge Note dated 01/04/24 at 20:27 (8:37 PM) found the following: The resident left the faciity on [DATE] at 9:00 PM. The transfer note described the resident as having blistering and peeling skin to bilateral feet and calves. The transfer note was electronically signed by Registered Nurse (RN) #100 on 01/04/24 at 8:49 PM. Vitals at Time of Transfer: Temperature: 97.7 (36.5 C) (01/04/2024 17:53 (5:53 PM) Pulse: 55 (01/04/2024 17:53 (5:53 PM) Respirations: 18 (01/04/2024 17:53 (5:53 PM) Blood Pressure: 127/66 (01/04/2024 17:53 (5:53 PM) These vitals were not taken at the time of transfer but approximately three (3) hours prior to transfer. At the time of transfer the resident was marked as confused. A nursing note dated 01/05/24 at 1:02 AM stated that Resident (#19) was sent to (initials of local hospital) by MD order for evaluation and treatment for burns to bilateral lower extremities (BLE). The note stated the resident was in the bath and when water was let out it was reported that he had red skin and blisters to BLE. The note stated that the on call nurse was notified at 7:59 PM and the Medical Director (MD) was contacted and an order to send the resident out was obtained at 8:44 PM. Morphine 10 milligram (mg) was given by mouth previous to EMT arriving at 9:05 pm. The Emergency Medical Technicians (EMTs) left with the resident at 9:15 PM by ambulance on a stretcher. Electronic signature by RN #100 on 01/05/24 at 1:07 AM. The resident's general condition was marked as confused, required total care and required total assistance for feeding. The resident moved all extremities. He had blisters on both lower extremities. He was incontinent of bowel and bladder with impairments of speech. RN #100 electronically signed the note on 01/04/24 at 8:40 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview with the Nursing Home Administrator (NHA), on 01/12/24 at 3:40 PM by phone, the NHA stated when he arrived in Resident #19's room, the resident was moving all over the bed and flailing his arms and legs. When the NHA went to the NS he said he told RN #100 that Resident #19 needed something for pain immediately. A report from the local hospital where the resident was transferred revealed the resident had second degree burns to bilateral lower extremities and feet, left hand, bilateral buttocks and scrotum. The estimated surface area of the burns was 35%. At the local hospital the resident was given medications for pain including Morphine (injection 4 milligram) and Fentanyl (injection 100 microgram/2 milliliter). The resident was transported to a neighboring state burn center on 01/04/24 at 11:30 PM.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 30153 Based on observation, staff interviews, medical record review, temperature log review, facility reportable incident (FRI) review, and hospital record review, the facility failed to ensure one (1) of six (6) residents had an environment which was as free of accident hazards as was possible. Nurse Aide (NA) #99 failed to monitor the water temperature when filling the tub. In addition NA #99 failed to supervise this resident during the bathing process. After Resident #19 was placed in the tub, water at 134 degrees (F) was used to fill the tub. Resident #19 sustained second degree burns to the left hand, bilateral lower extremities and feet, bilateral buttocks and scrotum. This created an immediate jeopardy situation that began on 01/04/24 at 7:12 PM when the resident was placed in the water and it ended on 01/07/24 at 6:54 PM when the hot water in the facility was turned off. When the immediate jeopardy was removed the result was harm to Resident #19. Resident identifier: #19. Facility census: 44. Findings included: a) Facility Reportable Incident (FRI) A facility reported incident was received at the state agency on 01/04/24. The report stated Nurse Aide (NA) #99 put Resident #19 into a whirlpool tub. She filled the tub to the knee level. The nurse aide realized the water was too warm. She had another aide try to adjust the water. The nurse aide admitted to not looking at the water temperature and this resulted in Resident #19 receiving severe burns to lower legs, feet, thighs, and left hand. The facility reported the immediate action taken was to suspend the nurse aide, take all tubs out of service and check for malfunction. Adult protective services were notified, as well as, the ombudsman, the local sheriff's department, and the nurse aide registry. A second facility reported incident dated 01/04/24 related to Resident #19 was also received by the state agency. This incident stated the registered nurse did not assess or treat a resident with severe burns timely. The immediate action taken was a suspension of the registered nurse in addition to the nurse aide and a shutdown of the bathtubs. A third facility reported incident dated 01/04/24 was sent to the state agency. This incident stated MS #76 had been monitoring water temperatures for over six (6) months which did not meet regulatory guidelines. MS #76 failed to report the temperatures or attempt to make any changes to meet regulatory compliance. The report revealed MS #76 said he was aware of the guidelines for water temperature and chose to keep it warmer per staff request. The five (5) day follow up report obtained on 01/09/24 revealed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	After reviewing camera and interviewing staff (Registered Nurse #100) was asked by CNA (ceritfied nurse assistant) that was giving (Resident #19) his bath to assess him. Another CNA asked nurse to assess him. Finally at 7:36 she went to shower room and left at 7:37. At 8:44 she got order to send to ER (emergency room). No 1st aide administered by unit nurse until 9:05. Nurse (Registered Nurse #100) sent home until investigation over. (Registered Nurse #100) failed to assess (Resident #19) when asked 3 times by CNAs. Did not administer treatment in a timely manner. I find this report to be substantiated for neglect of resident. (Registered Nurse #100) will be removed from schedule and her agency will be notified of decision. Excessive delay in treatment. This report was completed by the social service supervisor. A five day follow up to the immediate report for Certified Nurse Aide (NA) #41 revealed: After reviewing camera and interviewing NA #41 who was called to shower room and found the water too hot and adjusted water temperature. She was seen on camera leaving the shower room and going to nurses station but camera has no sound. I find this to be substantiated. NA #41 did adjust water but failed to assist in maintaining safety of resident. NA #41 sent home until investigation is done. I find this report to be substantiated for neglect of resident. NA #41 will be removed from schedule and her agency will be notified of decision. This report was completed by the social service supervisor. b) Facility Entrance During the entrance conference with the Assistant Nursing Home Administrator (ANHA) and the DON, on 01/09/24 at 12:25 PM, the DON stated Resident (#19) had received third degree burns to both lower extremities during a tub bath on the evening of 01/04/24. Resident #19 had been transferred to a local hospital and then transferred to an out of state burn unit. c) Resident #19 Resident #19 was admitted to the facility 10/12/17. Medical diagnoses included dementia with behavioral disturbances, unspecified psychosis not due to a substance or known physiological condition, peripheral vascular disease (PVD), alcohol dependence in remission, Fabry's disease, and high blood pressure. No Brief Interview for Mental Status (BIMS) was able to be obtained as the only verbal response was grunting. The resident was incontinent of bowel and bladder and required total care. The state of [NAME] Virginia served as health care surrogate for this resident. d) Timeline A timeline provided by the facility revealed Resident #19 was taken to the tub room on 01/04/24 at 7:12 PM by Nurse Aide (NA) #99. The following information is a review of the videotape of the hallway activity conducted by the Social Worker (SW) and the Minimum Data Set (MDS) Coordinator. This video was on 01/04/24 and reviewed on 01/05/24. 7:12 PM Resident #19 was taken to the tub room by Nurse Aide (NA) #99. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7:16 PM NA #99 out in the hall times two (2) and back to the tub room. 7:17 PM NA #99 out of the tub room-went to Resident #19's room and returned to the tub room. 7:20 PM NA #99 to Nurses Station (NS) then part way up hall got NA #41 and together they went to the tub room. 7:21 PM NA #41 leaves the tub room and goes to the NS back to the tub room and back to NS. 7:23 PM NA #41 in NS and leaves the NS (nurses station) at 7:24 PM. 7:26 PM NA #41 in the tub room then to NS at 7:27 PM. 7:29 PM NA #99 out in the hall to the linen cart and returns to the tub room. 7:33 PM NA #99 to NS and appears to be returning to the tub room. NA #99 gets NA #59 who is coming down the hall and they both go to the tub room together at 7:34. 7:35 PM NA #59 to NS. 7:36 PM NA #59 and RN #100 to tub room 7:36 PM NA #41 at NS 7:37 PM RN #100 returns to NS 7:52 PM NA #99 to NS and back to tub room 7:54 PM NA #99 to NS and back to tub room 8:00 PM RN #100 to tub room 8:02 PM RN #100 to NS 8:04 PM NA #63 arrives from Unit A1 to assist. 8:08 PM NA #41 leaves NS and goes to the tub room. 8:12 PM Resident #19 is taken back to his room. 8:15 PM NA #59 to NS and back to Resident #19's room 8:22 PM NA #41 to NS and then back to Resident #19's room 8:25 PM NA #63 leaves Resident #19's room, goes to the linen cart and returns to Resident #19's room. 8:28 PM NA #63 leaves Resident #19's room and returns with more linens. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	8:33 PM NA #63 leaves Resident #19's room and returns with more linens. 8:38 PM NA #63 to NS and then to tub room 8:40 PM NA #59 to the tub room and then NS 8:41 PM NA #63 and #59 return to Resident #19's room. 8:42 PM NA #59 goes down B1 hall then returns to Resident #19's room. 8:43 PM NHA (nursing home administrator) on the unit and immediately goes to the tub room then NS and then to Resident #19's room. A review of a nursing progress note by RN #100 revealed the resident was transferred on 01/04/24 at 9:15 PM to the local hospital. Resident #19 was documented to have blistering and peeling skin to bilateral feet and calves. Vitals were documented from three (3) hours prior to transfer: Temperature: 97.7 (36.5 C) (01/04/24 17:53 (5:53 PM) Pulse 55 (01/04/24 17:53 (5:53 PM) Respiration: 18 (01/04/24 17:53 (5:53 PM) Blood Pressure: 127/66 (01/04/24 17:53 (5:53 PM) e) Investigation Statements -HSW (health service worker) #99 Statement dated 01/04/24 as follows: I was giving resident B110b (#19) a bath, as the last bit of water was draining out I noticed he had a blister on the back of his foot. I then went to the nurses station to tell the nurse (RN #100). she said she would come look at it shortly. I waited a few minutes and noticed more blisters were showing up so I went to get the other aide on the hall (name of aide) (HSW #59). She looked at it and also went to tell the nurse she needs to come look at it now. The nurse came to look at it and said she'd call the on call nurse to see what to do next. (see whether he'd need to be sent out or not.) HSW #99, #59 and #63 (identifiers used instead of names) transferred him to his wheelchair after letting some time go by to see what the nurse wanted us to do, then took him to his room, got him in bed, and laid cold compresses on his feet and legs to stop further blistering. Typed as written. -HSW #41 Statement dated 01/04/24 as follows: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	I am floating unit to unit. I came over to B. As I was walking down the unit HSW #99 waved me down and asked me to lower the water temp. I walked in and put my hand in the water and said that's hot. the [sic] looked at the temp gauge and it was 134. The water was past his knees but not running. I immediately turned the temp down and ran cold water in the bath. It cooled down and went out of the bath back to my task I was doing. Then when I walked back up the hall. I overheard he had blisters and recalled what happened. 1/4/24 9:01 pm I knew the bathtub would go to 140 but I didn't report it because the other staff told me it was normal and how to fix it. Typed as written. -HSW #59 Statement (first name of HSW #59) came to get me to see if I could get the nurse to look at Resident #19 because she thought his feet looked bad and the nurse to her she would look at them when he got back into bed. So I went to the tub room to look at them and seen they were badly blistered on the top and sides and a blister on his shin (left). After I seen them I went to the nurses station to tell the nurse she needed to come look at him. She said Why do they look bad? I told her no you want to come now. The nurse finally came into the tub room to see his feet when she saw the she asked if Resident #19 had edema? I told her yes, but that ' not the problem. The nurse then said she will go check the computer to see if day shift reported it. I told her it was from the water and those were burns because it looked like his skin was melting off. Resident #19 was left in the empty tub for awhile after and I decided he needed to be moved to his room via w/c (wheel chair) because he was ripping his skin off his legs by rubbing them together and ripping the skin off his feet by rubbing them on the drain. We put him to be and placed wet rags on his burns and stayed with him trying to keep him comfortable waiting to see what was going to happen. Stayed with him until EMS came. Signed by HSW #59 with date of 01/05/24. -Nursing Home Administrator (NHA) statement on 01/09/24 at 10:04 AM. I arrived at Hopemont once being made aware of this issue of the burn. I went to the resident floor. Nurse (last name) RN #100 was at the nurses station. She said to me (Resident first name) #19 is in his room. I went to his room and CNA staff advised they repeatedly told (RN first name) RN #100 that resident (resident first name) #19 was burned and she needed to look at him. They said she only momentarily observed him while in the tub and left the bathroom. They got him out of the tub and took him to his room. I observed Resident #19 and stated he is in obvious discomfort and pain that needs to be addressed. They stated the nurse never came to his room. My involvement and goal was to see that appropriate steps regarding addressing this issue were implemented to identify, correct, process, and investigate the matter fully and thoroughly. I went to the nurses station after watching the resident writhing in pain. I advised RN #100 he needs pain management now. I asked if she had been to his room. She said no and asked if she should call the doctor. I told her something needs to be done now. Further I learned that the doctor ordered the resident sent out and that it was almost 30 minutes before RN #100 even called 911. She in no way assessed the resident and his care needs. I helped interview her with the social worker. She excused her action on training and orientation. I explained as a long term RN and having worked here before she was well aware of the process, care responsibility, appropriate reaction to resident need and that emergency care is immediate paperwork second. She was removed from the schedule -RN #100 Statement (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This nurse was at nurses desk when first CNA came out to desk from shower room and asked if resident's (Resident #19) feet normally peel. Told CNA I would check on it. Other CNA approached several minutes later and asked nurse to come and assess residents feet. This nurse went to assess feet. Lower part of legs about 1 inch red and feet were red, blistering and starting to peel. Attempted to contact A! to get phone numbers to try and contact on call. There was no answer. Attempted to message on call but reply not immediate. Got on call number from another staff and (unable to determine this word). Informed of situation. On call supposed to re-contact. Contacted MD for order to send out after second assessment with blisters large and redness moving up his legs. Delay in call back from on call. MD gave permission to send out. Contacted back by phone and several minutes later contacted by ADON. Started process to send out. Called 911 and gave report. Contacted MD back as ADON arrived and went to see resident to get order for pain med. Paper work put together and EMS arrived after giving pain med. Signed by RN #100. There was no date nor times when this statement was to when it was written and no times when calls were made or resident assessments completed. A review of of nursing progress notes titled Nursing transfer/Discharge Note dated 01/04/24 at 20:27 (8:37 PM) found the following: The resident left the faciity on [DATE] at 9:00 PM. The transfer note described the resident as having blistering and peeling skin to bilateral feet and calves. The transfer note was electronically signed by Registered Nurse (RN) #100 on 01/04/24 at 8:49 PM. The order from the physician to send the resident out of the facility was obtained by the RN at 8:44 PM. The reportable record showed the nurse aides (#41 and #99) first began asking RN #100 for assistance and to assess Resident #19 due to blisters from the hot water on 01/04/24 at 7:36 PM. f) A review of the water temperature logs revealed the following: Water Temperature Leaving Mixing Valve, located in the Potato Room i.e., boiler room, which supplies hot water to resident care areas as follows: Water Temperatures: January 2023 01/03/23 122 degrees (F), 01/04/23 120 degrees (F), 01/05/23 118 degrees (F), 01/06/23 124 degrees (F), 01/09/23 120 degrees (F), 01/10/23 126 degrees (F), 01/11/23 122 degrees (F), 01/12/23 120 degrees (F), 01/15/23 120 degrees 126 degrees (F), 01/18/23 124 degrees (F), 01/19/23 122 degrees (F), 01/20/23 120 degrees (F), , 01/24/23 126 degrees (F), 01/25/23 122 degrees (F), 01/26/23 126 degrees (F), 01/27/23 124 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), February 2023 02/02/23 124 degrees (F), 02/03/23 124 degrees (F), 02/06/23 126 degrees (F), 02/07/23 124 degrees (F), 02/08/23 130 degrees (F),02/13/23 126 degrees (F), 02/14/23 124 degrees (F), 02/15/23 128 degrees (F), 02/16/23 126 degrees (F), 02/17/23 128 degrees (F), 02/21/23 124 degrees (F), 02/22/23 128 degrees (F), 02/23/23 126 degrees (F), 02/24/23 128 degrees (F), 02/27/23 120 degrees (F) March 2023 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	03/01/23 126 degrees (F), 03/02/23 120 degrees (F), 03/03/23 124 degrees (F), 03/06/23 130 degrees (F), 03/07/23 124 degrees (F), 03/08/23 126 degrees (F), 03/09/23 126 degrees (F), 03/10/23 130 degrees (F), 03/16/23 120 degrees (F), 03/20/23 130 degrees (F), 03/21/23 130 degrees (F), 03/22/23 119 degrees (F), 03/23/23 124 degrees (F) 03/27/23 124 degrees (F), 03/28/23 128 degrees (F) April 2023 04/03/23 120 degrees (F), 04/04/23 126 degrees (F), 04/05/23 124 degrees (F), 04/06/23 119 degrees (F), 04/07/23 121 degrees (F), 04/10/23 120 degrees (F), 04/11/23 124 degrees (F), 04/12/23 123 degrees (F), 04/13/23 121 degrees (F), 04/14/23 115 degrees (F), 04/17/23 125 degrees (F), 04/18/23 120 degrees (F), 04/19/23 119 degrees (F), 04/20/23 121 degrees (F), 04/21/21 122 degrees (F), 04/24/23 130 degrees (F), 04/25/23 128 degrees (F), 04/26/23 115 degrees (F), 04/28/23 120 degrees (F) May 2023 05/01/23 120 degrees (F), 05/02/23 124 degrees (F), 05/03/23 122 degrees (F), 05/04/23 122 degrees (F), 05/05/23 118 degrees (F), 05/10/23 116 degrees (F), 05/11/23 124 degrees (F), 05/15/23 120 degrees (F), 05/16/23 126 degrees (F), 05/17/23 130 degrees (F), 05/18/23 120 degrees (F), 05/19/23 118 degrees (F), 05/22/23 122 degrees (F), 05/23/23 120 degrees (F), 05/24/23 116 degrees (F), 05/26/23 130 degrees (F), 05/29/23 130 degrees (F), 05/30/23 120 degrees (F), 05/31/23 124 degrees (F) June 2023 06/01/23 120 degrees (F), 06/02/23 112 degrees (F), 06/05/23 120 degrees (F), 06/06/23 116 degrees (F), 06/07/23 120 degrees (F), 06/08/23 130 degrees (F), 06/09/23 130 degrees (F), 06/12/23 118 degrees (F), 06/13/23 126 degrees (F), 06/14/23 122 degrees (F), 06/15/23 124 degrees (F), 06/16/23 118 degrees (F), 06/19/23 121 degrees (F), 06/20/23 114 degrees (F), 06/21/23 120 degrees (F), 06/22/23 122 degrees (F), 06/23/24 116 degrees (F), 06/26/23 131 degrees (F), 06/27/23 122 degrees (F), 06/28/23 124 degrees (F), 06/29/23 120 degrees (F), 06/30/23 124 degrees (F) July 2023 07/05/23 121 degrees (F), 07/06/23 120 degrees (F), 07/07/23 120 degrees (F), 07/10/23 121 degrees (F), 07/11/23 116 degrees (F), 07/14/23 120 degrees (F), 07/17/23 122 degrees (F), 07/18/23 132 degrees (F), 07/19/23 124 degrees (F), 07/20/23 114 degrees (F), 07/21/23 128 degrees (F),07/26/23 120 degrees (F), 07/27/23 118 degrees (F), 07/28/23 122 degrees (F), 07/31/23 120 degrees (F) August 2023 08/01/23 120 degrees (F), 08/02/23 118 degrees (F), 08/03/23 120 degrees (F), 08/04/23 124 degrees (F), 08/07/23 120 degrees (F), 08/08/23 121 degrees (F), 08/09/23 118 degrees (F), 08/10/23 122 degrees (F), 08/11/23 130 degrees (F), 08/14/23 121 degrees (F), 08/15/23 129 degrees (F), 08/16/23 118 degrees (F), 08/18/23 136 degrees (F), 08/21/23 120 degrees (F), 08/22/23 124 degrees (F), 08/23/23 133 degrees (F), 08/24/23 114 degrees (F), 08/25/23 126 degrees (F), 08/28/23 130 degrees (F), 08/29/23 140 degrees (F), 08/30/23 128 degrees (F), (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	September 2023 09/01/23 125 degrees (F), 09/05/23 128 degrees (F), 09/06/23 130 degrees (F), 09/07/23 126 degrees (F), 09/08/23 130 degrees (F), 09/11/23 126 degrees (F), 09/12/23 124 degrees (F), 09/13/23 121 degrees (F) , 09/18/23 130 degrees (F), 09/19/23 126 degrees (F), 09/20/23 124 degrees (F), 09/21/23 120 degrees (F), 09/29/23 130 degrees (F) October 2023 10/02/23 125 degrees (F), 10/03/23 130 degrees (F), 10/04/23 132 degrees (F), 10/05/23 130 degrees (F) 10/09/23 140 degrees (F), 10/10/23 138 degrees (F), 10/11/23 10/13/23 130 degrees (F), 10/16/23 120 degrees (F), 10/17/23 130 degrees (F), 10/18/23 124 degrees (F), 10/19/23 124 degrees (F),10/20/23 128 degrees (F), 10/24/23 132 degrees (F), 10/25/23 128 degrees (F), 10/26/23 130 degrees (F), 10/27/23 142 degrees (F), 10/30/23 140 degrees (F), 10/31/23 132 degrees (F) November 2023 11/01/23 128 degrees (F), 11/02/23 132 degrees (F), 11/03/23 141 degrees (F), 11/06/23 140 degrees (F), 11/07/23 128 degrees (F), 11/08/23 130 degrees (F), 11/09/23 134 degrees (F), 11/13/23 130 degrees (F), 11/14/23 126 degrees (F), December 2023 12/01/23 130 degrees (F), 12/04/23 130 degrees (F), 12/05/23 132 degrees (F), 12/06/23 140 degrees (F), 12/07/23 128 degrees (F), 12/08/23 132 degrees (F), 12/11/23 130 degrees (F), 12/12/23 126 degrees (F), 12/13/23 140 degrees (F), 12/14/23 140 degrees (F), 12/15/23 138 degrees (F), 12/20/23 130 degrees (F), 12/21/23 126 degrees (F), 12/22/23 140 degrees (F), 12/26/23 128 degrees (F), 12/28/23 132 degrees (F), 12/29/23 130 degrees (F) January 2023 There were no temperatures avaialble prior to 01/04/24 when a temperature of 140 degrees (F) was recorded after the incident. Record review revealed water temperatures continued to be above 110 degrees (F) on 01/05/24, 01/06/24, and on 01/07/24. These temperatures logs revealed temperateurs were taken at four (4) sinks, and in the shower room. There were no temperatures recorded on weekends and holidays. Record review on 01/09/24 at 2:18 PM, revealed no evidence was provided during the survey to show the corrective action or adjustments to the resident hot water system when water temperatures were routinely recorded above 110 degrees Fahrenheit (F) monthly from January 2023 through December 2023. Approximately 121 days had temperatures logged above 110 degrees Fahrenheit. These temperatures were logged by the Maintenance Department Staff for resident corridors A1, B1, and resident areas ([NAME]) and Dining Room ([NAME]). An interview on 01/09/24 at 2:20 PM. with the Assistant Administrator verified this finding. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Nurse Educator (NE) #78 An email from the nurse educator to administrative staff dated 01/07/24 at 9:54 AM revealed NE #78 was still concerned about the hot water in the sinks. In the email the nurse educator explained that the staff had been told not to use the hot water because it had been registering over 110 degrees (F). The nurse educator stated she was concerned that residents would use the sink and nursing could not monitor the situaiton. In her email the Nurse Educator said that Licensed Practical Nurse (LPN) #46 had asked about shutting the hot water off and was told it could not be done. On 01/11/24 the administrator gave a statement to the surveyor indicating he ordered access to all hot water be shut down in the resident care areas on 01/07/24 at 6:54 PM. g) The Quality Assurance and Performance Improvement Committee (QAPI) met on 01/09/24 at approximately 10:00 a.m. to discuss the current situation of water temps for resident care. Documentation revealed that water temps were being checked every hour since 01/05/24 at the four (4) main sinks on Resident corridors of A1 and B1 and the resident showers on the corridors of A1 and [NAME] 1, with this documentation forwarded to Administration for review. The showers had not been used since 01/04/24. Repairs were initiated on the hot water system on 01/08/24 to isolate the hot water distributed to the resident care areas and residents currently have no access to hot water until the final repairs are made. Prior to the time of survey, potential mechanical issues with an isolation valve, hot water tank thermostat, and a water system distribution mixing valve and gauge were discovered. The isolation valve, thermostat, and mixing valve gauge had been replaced prior to survey. The water system distribution mixing valve was being investigated further with parts being ordered for repair during survey. Nursing staff were notified that they would be using wipes and no rinse shampoo and body wash until further notice. Per the QAPI meeting minutes, reeducation was provided to staff reiterating appropriate hot water temperatures and completing maintenance work orders if issues are suspected with the temperature of the water system. Phone interview on 01/09/24 at approximately 11:36 AM., with the Director of Facilities and Plant Operations #97 revealed the perceived issue with the hot water system was a faulty thermostat on the hot water tank serving resident corridors A1 and B1 of the Nursing Building. The issue with the thermostat was believed to have failed in the close position and was discovered mid-morning on Friday, January 5th. The hot water system was drained and refilled with 55-degree city water. An isolation valve was added on Monday, January 8th. Interview also noted that hot water temperatures were not supposed to be above 110 degrees (F). Observation on 01/09/24 at approximately 12:14 PM. revealed the only hot water being provided was to the Dining Areas. The temperature of hot water at a hand sink in the Dining area was noted as 109.1 degrees (F). Hot water to the other resident areas such as Corridor A1, B1, and corridor [NAME] 1 was isolated off in the basement and handles removed form faucets and fixtures to prevent residents from accidentally turning on the hot water while repairs and adjustments were made to the system. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 01/09/24 at approximately 1:03 PM., with Building Maintenance Mechanic #95 revealed that an issue with a thermostat on a hot water tank in the basement (Potato Room) was discovered and replaced. A ball valve was also replaced as a suspected back-feed elimination. A gauge for the mixing valve for the water leaving this area to the resident areas was also replaced. Interview noted that a daily log of the water temperatures was maintained in each mechanical room. Interview noted that he was not aware that temperatures above 110 degrees (F) needed to be reported and only recorded what the gauges read and was not previously aware of what the water temperatures were supposed to be maintained at. Phone interview on 01/10/24 at approximately 9:43 AM, with the Maintenance Supervisor #76 noted that he had been the Maintenance Supervisor for approximately 5 years. The interview revealed he recorded the temperatures of the hot water system as noted on the gauges and was aware that the temperatures were supposed to be maintained at 110 degrees (F). He also noted he tried to keep temperatures warm enough on the floors. He said nursing would let him know if the temperatures seemed too cold. Interview noted that he did not report the daily/monthly temperature logs to any committee or had not been asked for them. The Office of Health Facilities Policy (Policy OHF.LS.0002) for Preventive Maintenance and Casualty Prevention Plan was updated to include an effective date based upon the date of approval on the signature page. This policy outlined the testing and preventative maintenance procedures and documentation requirements for the Plant Operations, Maintenance, and Engineering Staff. Documentation from the Preventative Maintenance and Casualty Prevention Plan is monitored through safety surveillance, which is conducted hospital wide monthly by members of the Safety Committee. These inspection reports are to be given to the Safety Officer, who will then assign corrective action from the appropriate department. This policy outlines that all boiler room equipment gauges are to be visually monitored daily and that patient hot water is not to exceed 110 degrees Fahrenheit with any deviations reported the Maintenance Department immediately. In a conversation between the local plumber and NHA, on 01/11/24 at 3:45 PM, the plumber stated the mixing value was defective and would have to be replaced as well as relocating the mixing valve. There were no mixing valves available locally and would have to be ordered. The plumber also suggested that filters be built into the water system to collect dirt. The NHA comment was Whatever it takes.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 30153 Based on a review of the orientation records, and staff interviews, the facility failed to ensure licensed staff and nurse aides were able to demonstrate competency skills and techniques necessary to care for resident needs. Registered Nurse #100 (RN) failed to render aid timely to Resident #19 who sustained third degree burns. A nurse aide (NA) failed to ensure one (1) of six (6) resident's safety during a bath. The nurse aide exposed the resident to water at 134 degrees Fahrenheit (F). This caused third degree burns to the resident. Resident identifier: #19. Staff identifiers: Registered Nurse (RN) #100, Nurse Aide #99. This failed practice created an immediate jeopardy situation that began on 01/04/24 when the resident was place in the bath and ended on 01/22/24 when all staff completed competencies on safe bathing. Water temperatures more than 110 degrees (F) were recorded from January 3, 2024, until the hot water access to resident care areas was shut down on 01/07/24 at 6:54 PM. This had the potential to affect all residents residing in the facility. Facility census: 44. Findings included: a) Facility Reportable Incident (FRI) A facility reported incident was received at the state agency on 01/05/24. The report stated Nurse Aide #99 put Resident #19 into a whirlpool tub. She filled the tub to the knee level. The nurse aide realized the water was too warm. She had another aide try to adjust the water. The nurse aide admitted to not looking at the water temperature and this resulted in Resident #19 receiving severe burns to lower legs, feet, thighs, and left hand. The facility reported the immediate action taken was to suspend the nurse aide, take all tubs out of service and check for malfunction. Adult protective services were notified, the ombudsman, the local sheriff's department, and the nurse aide registry. A second facility reported incident dated 01/04/24 related to Resident #19 was also received by the state agency. This incident stated the registered nurse did not assess or treat a resident with severe burns timely. The immediate action taken was a suspension of the registered nurse in addition to the nurse aide and a shutdown of the bathtubs. A third facility reported incident dated 01/05/24 was sent to the state agency. This incident stated MS #76 had been monitoring water temperatures for over six (6) months that did not meet regulatory guidelines. MS #76 failed to report the temperatures or attempt to make any changes to meet regulatory compliance. The report revealed MS #76 said he was aware of the guidelines for water temperature and chose to keep it warmer per staff request. The five (5) day follow up report obtained on 01/09/24 revealed the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	After reviewing camera and interviewing staff (Registered Nurse #100) was asked by CNA (ceritfied nurse assistant) that was giving (Resident #19) his bath to assess him. Another CNA asked nurse to assess him. Finally at 7:36 she went to shower room and left at 7:37. At 8:44 she got order to send to ER (emergency room). No 1st aide administered by unit nurse until 9:05. Nurse (Registered Nurse #100) sent home until investigation over. (Registered Nurse #100) failed to assess (Resident #19) when asked 3 times by CNAs. Did not administer treatment in a timely manner. I find this report to be substantiated for neglect of resident. (Registered Nurse #100) will be removed from schedule and her agency will be notified of decision. Excessive delay in treatment. This report was completed by the social service supervisor. A five day follow up to the immediate report for Certified Nurse Aide (NA) #41 revealed: After reviewing camera and interviewing NA #41 who was called to shower room and found the water too hot and adjusted water temperature. She was seen on camera leaving the shower room and going to nurses station but camera has no sound. I find this to be substantiated. NA #41 did adjust water but failed to assist in maintaining safety of resident. NA #41 sent home until investigation is done. I find this report to be substantiated for neglect of resident. NA #41 will be removed from schedule and her agency will be notified of decision. This report was completed by the social service supervisor. Resident #19 was admitted to the facility 10/12/2017. Medical diagnoses included dementia with behavioral disturbances, unspecified psychosis not due to a substance or known physiological condition, peripheral vascular disease (PVD), alcohol dependence in remission, Fabry's disease, and high blood pressure. No Brief Interview for Mental Status (BIMS) was able to be obtained as the only verbal response was grunting. A review of nursing progress note revealed the resident was transferred on 01/04/24 at 9:00 PM. Resident #19 was documented to have blistering and peeling skin to bilateral feet and calves. Medical Record Review revealed the resident's general condition was marked as confused, required total care, and required total assistance for feeding. The resident moved all extremities. He had blistering to both lower extremities. He was incontinent of bowel and bladder with impairments of speech. RN #100 electronically signed her note on 01/04/24 at 8:40 PM. A nursing note dated 01/05/24 at 1:02 AM stated that Resident (#19) sent to (initials of local hospital) by MD order for eval and treat for burns to BLE (both lower extremities). The resident was in bath and when water was let out it was reported that he had red skin and blisters BLE. The note stated Contacted on call at 7:59 pm. MD notified and order for send out obtained and put in 9:10pm. Morphine 10 mg given P.O. before EMT arriving at 9:05pm. EMT left with resident at 9:15PM by ambulance on a stretcher. RN #100 electronically signed this note on 01/05/24 at 1:07 AM. b) A video review with statements was provided to the surveyor by the facility The following was a review of the video tape of the hallway activity conducted by the Social Worker (SW) and the Minimum Data Set (MDS) Coordinator. This video was on 01/04/24 and reviewed on 01/05/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7:12 PM Resident #19 was taken to the tub room by Nurse Aide (NA) #99. 7:16 PM NA #99 out in the hall times two (2) and back to tub room. 7:17 PM NA #99 out of tub room-went to Resident #19's room and returned to tub room. 7:20 PM NA #99 to Nurses Station (NS) then part way up hall got CNA #41 and together they went to tub room. 7:21 PM NA #41 leaves the tub room and goes to the NS back to tub room and back to NS. 7:23 PM NA #41 in NS and leaves the NS at 7:24 PM. 7:26 PM NA #41 in tub room then to NS at 7:27 PM. 7:29 PM NA #99 out in hall to linen cart and returns to tub room. 7:33 PM NA #99 to NS and appears to be returning to the tub room. CNA #99 gets CNA #59 who is coming down the hall and they both go to the tub room together at 7:34. 7:35 PM NA #59 to NS. 7:36 PM NA #59 and RN #100 to tub room 7:36 PM NA #41 at NS 7:37 PM RN #100 returns to NS 7:52 PM NA #99 to NS and back to tub room 7:54 PM NA #99 to NS and back to tub room 8:00 PM RN #100 to tub room 8:02 PM RN #100 to NS 8:04 PM NA #63 arrives from Unit A1 to assist. 8:08 PM NA #41 leaves NS and goes to tub room. 8:12 PM Resident #19 is taken back to his room. 8:15 PM NA #59 to NS and back to Resident #19's room 8:22 PM NA #41 to NS and then back to Resident #19's room 8:25 PM NA #63 leaves Resident #19's room, goes to linen cart and returns to Resident #19's room. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8:28 PM NA #63 leaves Resident #19's room and returns with more linens. 8:33 PM NA #63 leaves Resident #19's room and returns with more linens. 8:38 PM NA #63 to NS and then to tub room 8:40 PM NA #59 to tub room and then NS 8:41 PM NA #63 and #59 return to Resident #19's room. 8:42 PM NA #59 goes down B1 hall then returns to Resident #19's room. 8:43 PM NHA (nursing home administrator) on unit and immediately goes to tub room then NS and then to Resident #19's room. 8:44 PM ADON (assistant director of nursing) was on the unit and immediately went to Resident #19's room. 8:45 PM ADON running from unit to get supplies. 8:45 PM Building and Grounds Manager (BGM) #76 on unit and goes to tub room. 8:47 PM NHA and BGM #76 in tub room 8:49 PM BGM #76 checking water in hall 8:50 PM CNA #63 to NS and returns to Resident #19's room. 8:56 PM NHA goes to the Nursing Station. 8:57 PM Social Service Supervisor (SSS) #70-Advocate arrives on the unit. 8:57 PM CNA #63 running down hall for more supplies. 9:00 PM CNA #63 returning with supplies. 9:03 PM SSS #70 leaves unit 9:04 PM NHA goes to tub room. 9:05 PM CNA #63 rushing off unit. 9:05 PM RN (registered nurse) #100 leaves NS and goes to Resident #19's room. 9:06 PM RN #100 returns to NS 9:17 PM EMS leaves unit with Resident #19 (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	9:18 PM NHA and ADON on unit at NS 9:19 PM NHA and ADON along with NA #99 walking off unit 9:21 PM RN #100 pushes med cart into hall 1:20 AM RN #100 clocked out and was escorted out of building by ADON. c) Assistant Director of Nursing (ADON) In a statement by the Assistant Director of Nursing (ADON) stated (first name of RN #100) was called to the bathroom for reported blisters of Resident #19 more than once. Eventually RN #100 went to observe, then left the room after 1.5 minutes at 7:36 pm. RN #100 did not render first aid or pain management. RN #100 went back to desk at 7:36 pm and did not call appropriate help (Doctor, On call nurse, 911, EMS, other unit nurse) until 8:25 pm when she contacted the RN on call. Between 8pm and 8:25 pm she did get the doctor's order to send out. 8:26 pm doctors order to send out written. EMS records show she did not call them until 8:54 pm. d) The Nursing Home Administrator's (NHA) statement dated 01/09/24 at 10:04 AM The NHA said he arrived at the facility once he was made aware of this issue of the burn. NHA said he went to the resident floor. RN #100 was at the nurse's station. She said to me (Resident first name) #19 was in his room. NHA said he went to Resident #19's room and nurse aide staff advised they repeatedly told RN #100 that Resident #19 was burned and she needed to look at him. They said she only momentarily observed him while in the tub and left the bathroom. They got him out of the tub and took him to his room. NHA said he observed Resident #19 and stated he was in obvious discomfort and pain that needed addressed. The nurse aides stated the nurse never came to his room. The NHA said his involvement and goal was to see that appropriate steps regarding addressing this issue were implemented to identify, correct, process, and investigate the matter fully and thoroughly. NHA said he went to the nurses' station after watching the resident writhing in pain. He advised RN #100 that he needed pain management now. He asked if she had been to his room. She said no and asked if she should call the doctor. NHA said he told her something needed done now. Further he said he learned the doctor ordered the resident sent out and that after receiving the order 30 minutes passed before RN #100 called 911. NHA said in no way did RN #100 assess the resident and his care needs. The NHA said RN #100 excused her action on training and orientation. NHA said he explained as a long-term RN and having worked here before she was well aware of the process, care responsibility, appropriate reaction to resident need and that emergency care was immediate and paperwork was second. NHA said he told RN #100 in his opinion her actions clearly were a delay in treatment and neglect. NHA said he told RN #100 until the investigation was completed; she was removed from the schedule. On 01/10/24 at 10:24 AM a review of employee records for skills competencies was conducted for Registered Nurse (RN) #100. No evidence was found of a skills competency being completed during orientation dated 11/14/23. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	RN #100 scored on a scenario-based testing 86% on pain evaluation and management, and 67% on resident evaluation. No evidence was provided regarding skills demonstration or evaluation of returned demonstrations. e) Nurse Aide #99 On 01/10/24 at 10:24 AM a review of employee records for skills competencies was conducted for HSW #99. No evidence was found of a skills competency being completed during orientation dated 11/13/23. The New Staff Orientation Competency with a start date of 11/13/23 and a completion date of 11/14/23 found in the area titled Legend (How Met) under Section F. Other (Specify: Return Demonstration) handwritten Discussion, Verbalized Understanding. The areas found on the New Staff Orientation Competency included major topics of Initial Employee Orientation, Tour of Department and Facility, HIPPA Officer, Safety, Social Services, Ethics and Compliance, Quality Assurance, Infection Control, and Departmental Expectations/Tasks and Responsibilities. The Safety section included the following: Emergency Codes Emergency Preparedness Shelter in Place Water Management Plan Active Shooter Training Interim Life Safety Infection Control Fire Watch Plan Resident Safety Fire Safety Fire Drills Fire Watch Fire Extinguisher Pull Stations Emergency Exits (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Workplace Security Preventative Maintenance Requirements Maintenance Work Orders Resident Environment Resident Equipment General Environment Location of MSDS Manuals Labeling and Storing of Chemicals and other hazardous materials. Elopement Procedure f) On 01/11/24 at 10:40 AM in the presence of the Director of Nursing (DON), CNA #66 was interviewed. NA #66 stated that she showed new employees how to operate the tub and then has the new employee complete a return demonstration. When asked how this was documented, CNA #66 stated We used to have one (skills competency check off sheet) but I don't have one now. During the night of 01/04/24 into 01/05/24 the ADON educated the night shift staff that temperatures that exceed 110 degrees were not within regulation and should not be used on any resident. The staff included RN #100, HSW's (health service worker) #99, # 41, #59, #63, #60 and #85. g) Nurse Educator (NE) #78 An email from the nurse educator to administrative staff dated 01/07/24 at 9:54 AM revealed NE #78 was still concerned about the hot water in the sinks. In the email the nurse educator explains that the staff had been told not to use the hot water because it had been registering over 110 degrees (F). The nurse educator stated she was concerned that residents would use the sink and nursing could not monitor the situaiton. In her email the Nurse Educator said that Licensed Practical Nurse (LPN) #46 had asked about shutting the hot water off and was told it could not be done. NE #78 had a written statement dated 1/11/24. NE #78 statement reflected she worked on 01/05/24 on B -1 from 6:30 PM - 10:30 PM. She worked with Nurse Aide #63, #59, #87 on safe bathing, burns and maintenance orders. She also spoke with RN #62, and #22 on the subject as well. An in-service was held on bathing, burns and safe temperatures. This in-service had a post test. On 01/07/24 10 staff members attended; on 01/08/24 13 attended on 01/09/24 one (1) attended and on 01/10/24 one (1) attended. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Other discussions were held by the Staff Development Educator which included Bathing and burns with handouts that included a copy of the chain of command, flow chart for reporting process, assisting with a tub bath or shower, various bathing techniques, CMS chart Time and Temperature Relationship to Serious Burns, and a copy of the Maintenance Work Order. 11 staff attended on 01/07/24, 10 staff attended on 01/08/24, 1 attended on 01/09/24 and 01/10/24 respectively and 8 attended on 01/11/24. h) Maintenance Director and Maintenance Staff On 01/06/24 at 12:20 PM the Maintenance Director and maintenance staff was in -serviced. The in-services included the following information: Anytime the water Temp is Above 110 you must notify the charge nurse that the hot water is not to be used in that specific area and make corrections. You must document when notification was made and to whom. Typed as written.

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153 37324 Based on observation, record review, and staff interview the licensee failed to maintain hot water mechanical equipment in safe operating condition. According to CMS guidelines exposure at water temperature of 133 degrees Fahrenheit can lead to third degree burns in 15 seconds. Resident #19 was bathed in 134 degrees Fahrenheit water. Resident #19 sustained second degree burns to his feet, legs, thigh, and hand. The staff responsible for monitoring water temperatures and maintaining equipment knew the hot water had measured more than 110 degrees Fahrenheit (F) since January 2023. This caused an immediate jeopardy situation that began on 01/03/23 and ended on 01/07/24. This practice had the potential to affect all facility residents. Resident identifier: #19. Facility census 44. Findings included: a) Facility Reported Incident A facility reported incident was received at the state agency on 01/05/24. The report stated Nurse Aide #99 put Resident #19 into a whirlpool tub. She filled the tub to the knee level. The nurse aide realized the water was too warm. She had another aide try to adjust the water. The nurse aide admitted to not looking at the water temperature and this resulted in Resident #19 receiving severe burns to lower legs, feet, thighs, and left hand. The facility reported the immediate action taken was to suspend the nurse aide, take all tubs out of service and check for malfunction. Adult protective services were notified, the ombudsman, the local sheriff's department, and the nurse aide registry. A second facility reported incident dated 01/04/24 related to Resident #19 was also received by the state agency. This incident stated the registered nurse did not assess or treat a resident with severe burns timely. The immediate action taken was a suspension of the registered nurse in addition to the nurse aide and a shutdown of the bathtubs. A third facility reported incident dated 01/05/24 was sent to the state agency. This incident stated Maintenance Supervisor (MS) #76 had been monitoring water temperatures for over six (6) months that did not meet regulatory guidelines. MS #76 failed to report the temperatures or attempt to make any changes to meet regulatory compliance. The report revealed MS #76 said he was aware of the guidelines for water temperature and chose to keep it warmer per staff request. The five (5) day follow up report obtained on 01/09/24 revealed the following: After reviewing camera and interviewing staff (Registered Nurse #100) was asked by CNA (ceritfied nurse assistant) that was giving (Resident #19) his bath to assess him. Another CNA asked nurse to assess him. Finally at 7:36 she went to shower room and left at 7:37. At 8:44 she got order to send to ER (emergency room). No 1st aide administered by unit nurse until 9:05. Nurse (Registered Nurse #100) sent home until investigation over. (Registered Nurse #100) failed to assess (Resident #19) when asked 3 times by CNAs. Did not administer treatment in a timely manner. I find this report to be substantiated for neglect of resident. (Registered Nurse #100) will be removed from schedule and her agency will be notified of decision. Excessive delay in treatment. (continued on next page)

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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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This report was completed by the social service supervisor. A five day follow up to the immediate report for Certified Nurse Aide (NA) #41 revealed: After reviewing camera and interviewing NA #41 who was called to shower room and found the water too hot and adjusted water temperature. She was seen on camera leaving the shower room and going to nurses station but camera has no sound. I find this to be substantiated. NA #41 did adjust water but failed to assist in maintaining safety of resident. NA #41 sent home until investigation is done. I find this report to be substantiated for neglect of resident. NA #41 will be removed from schedule and her agency will be notified of decision. This report was completed by the social service supervisor. b) Facility Entrance During the entrance conference with the Assistant Nursing Home Administrator (ANHA) and the DON, on 01/09/24 at 12:25 PM, the DON stated Resident (#19) had received third degree burns to both lower extremities during a tub bath on the evening of 01/04/24. They said had been transferred to a local hospital and then transferred to an out of state burn unit. b) Record Review Record review on 01/09/24 2:18 PM, revealed no documentation was provided during the survey to show the corrective action or adjustments to the resident hot water system when water temperatures were routinely recorded above 110 degrees (F) monthly from August 2023 through December 2023 by the Maintenance Department Staff for resident corridors A1, B1, and resident areas Shower Room ([NAME]) and Dining Room ([NAME]). Interview on 01/09/24 at approximately 2:20 p.m. with the Assistant Administrator verified this finding. c) Maintenance Supervisor (MS) #76 A phone interview on 01/10/24 at approximately 9:43 a.m., with MS #76 noted he had been the Maintenance Supervisor for approximately 5 years. Interview revealed he recorded the temperatures of the hot water system as noted on the gauges and seemed to be aware that the temperatures were supposed to be maintained at 110 degrees Fahrenheit. He also noted that he tried to keep temperatures warm enough on the floors as Nursing would let him know if the temperatures seemed too cold. Interview noted that he did not report the daily/monthly temperature logs to any committee or had not been asked for them by any of the reporting committees, such as the Safety Committee or the Quality and Performance Improvement (QAPI) Committee. d) Preventative Maintenance and Casualty Prevention Plan Notes (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review on 01/10/24 at 12:37 p.m., revealed Preventative Maintenance and Casualty Prevention Plan notes state that Safety Surveillance is conducted hospital wide monthly by members of the Safety Committee. Reports of inspection are given to the Safety Officer who will then assign the deficiency correction to the proper department for action. Per the Preventative Maintenance and Casualty Prevention Plan these reports and corrective action documents are then also attached to the master copy of the Quality Committee minutes. Record review revealed no documentation provided during the survey to show that Safety Surveillance was reported to the Quality and Performance Improvement (QAPI) Committee from July 2023 through December 2023, as outlined in the Preventative Maintenance and Casualty Prevention Plan. e) Administrator and Assistant Administrator Interview On 01/10/24 at 1:10 PM during an interview the assistant administrator and the administrator agreed they had not looked at the hot water temperatures being recorded by the maintenance employee, nor had they checked to see if any preventative maintenance was being done to the hot water equipment. f) Resident #19 Record review revealed Resident #19 was admitted to the facility 10/12/17. Medical diagnoses included dementia with behavioral disturbances, unspecified psychosis not due to a substance or known physiological condition, peripheral vascular disease (PVD), alcohol dependence in remission, Fabry's disease, and high blood pressure. No Brief Interview for Mental Status (BIMS) was able to be obtained as the only verbal response was grunting. g) Water Temperature Log Review of temperatures taken at the mixing valve are as follows: January 2023 01/03/23 122 degrees (F), 01/04/23 120 degrees (F), 01/05/23 118 degrees (F), 01/06/23 124 degrees (F), 01/09/23 120 degrees (F), 01/10/23 126 degrees (F), 01/11/23 122 degrees (F), 01/12/23 120 degrees (F), 01/15/23 120 degrees 126 degrees (F), 01/18/23 124 degrees (F), 01/19/23 122 degrees (F), 01/20/23 120 degrees (F), , 01/24/23 126 degrees (F), 01/25/23 122 degrees (F), 01/26/23 126 degrees (F), 01/27/23 124 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), February 2023 02/02/23 124 degrees (F), 02/03/23 124 degrees (F), 02/06/23 126 degrees (F), 02/07/23 124 degrees (F), 02/08/23 130 degrees (F),02/13/23 126 degrees (F), 02/14/23 124 degrees (F), 02/15/23 128 degrees (F), 02/16/23 126 degrees (F), 02/17/23 128 degrees (F), 02/21/23 124 degrees (F), 02/22/23 128 degrees (F), 02/23/23 126 degrees (F), 02/24/23 128 degrees (F), 02/27/23 120 degrees (F) March 2023 03/01/23 126 degrees (F), 03/02/23 120 degrees (F), 03/03/23 124 degrees (F), 03/06/23 130 degrees (F), 03/07/23 124 degrees (F), 03/08/23 126 degrees (F), 03/09/23 126 degrees (F), 03/10/23 130 degrees (F), 03/16/23 120 degrees (F), 03/20/23 130 degrees (F), 03/21/23 130 degrees (F), 03/22/23 119 degrees (F), 03/23/23 124 degrees (F) 03/27/23 124 degrees (F), 03/28/23 128 degrees (F) (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	April 2023 04/03/23 120 degrees (F), 04/04/23 126 degrees (F), 04/05/23 124 degrees (F), 04/06/23 119 degrees (F), 04/07/23 121 degrees (F), 04/10/23 120 degrees (F), 04/11/23 124 degrees (F), 04/12/23 123 degrees (F), 04/13/23 121 degrees (F), 04/14/23 115 degrees (F), 04/17/23 125 degrees (F), 04/18/23 120 degrees (F), 04/19/23 119 degrees (F), 04/20/23 121 degrees (F), 04/21/21 122 degrees (F), 04/24/23 130 degrees (F), 04/25/23 128 degrees (F), 04/26/23 115 degrees (F), 04/28/23 120 degrees (F) May 2023 05/01/23 120 degrees (F), 05/02/23 124 degrees (F), 05/03/23 122 degrees (F), 05/04/23 122 degrees (F), 05/05/23 118 degrees (F), 05/10/23 116 degrees (F), 05/11/23 124 degrees (F), 05/15/23 120 degrees (F), 05/16/23 126 degrees (F), 05/17/23 130 degrees (F), 05/18/23 120 degrees (F), 05/19/23 118 degrees (F), 05/22/23 122 degrees (F), 05/23/23 120 degrees (F), 05/24/23 116 degrees (F)< 05/26/23 130 degrees (F), 05/29/23 130 degrees (F), 05/30/23 120 degrees (F), 05/31/23 124 degrees (F) June 2023 06/01/23 120 degrees (F), 06/02/23 112 degrees (F), 06/05/23 120 degrees (F), 06/06/23 116 degrees (F), 06/07/23 120 degrees (F), 06/08/23 130 degrees (F), 06/09/23 130 degrees (F), 06/12/23 118 degrees (F), 06/13/23 126 degrees (F), 06/14/23 122 degrees (F), 06/15/23 124 degrees (F), 06/16/23 118 degrees (F), 06/19/23 121 degrees (F), 06/20/23 114 degrees (F), 06/21/23 120 degrees (F), 06/22/23 122 degrees (F), 06/23/24 116 degrees (F), 06/26/23 131 degrees (F), 06/27/23 122 degrees (F), 06/28/23 124 degrees (F), 06/29/23 120 degrees (F), 06/30/23 124 degrees (F) July 2023 07/05/23 121 degrees (F), 07/06/23 120 degrees (F), 07/07/23 120 degrees (F), 07/10/23 121 degrees (F), 07/11/23 116 degrees (F), 07/14/23 120 degrees (F), 07/17/23 122 degrees (F), 07/18/23 132 degrees (F), 07/19/23 124 degrees (F), 07/20/23 114 degrees (F), 07/21/23 128 degrees (F),07/26/23 120 degrees (F), 07/27/23 118 degrees (F), 07/28/23 122 degrees (F), 07/31/23 120 degrees (F) August 2023 08/01/23 120 degrees (F), 08/02/23 118 degrees (F), 08/03/23 120 degrees (F), 08/04/23 124 degrees (F), 08/07/23 120 degrees (F), 08/08/23 121 degrees (F), 08/09/23 118 degrees (F), 08/10/23 122 degrees (F), 08/11/23 130 degrees (F), 08/14/23 121 degrees (F), 08/15/23 129 degrees (F), 08/16/23 118 degrees (F), 08/18/23 136 degrees (F), 08/21/23 120 degrees (F), 08/22/23 124 degrees (F), 08/23/23 133 degrees (F), 08/24/23 114 degrees (F), 08/25/23 126 degrees (F), 08/28/23 130 degrees (F), 08/29/23 140 degrees (F), 08/30/23 128 degrees (F), September 2023 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E148	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	09/01/23 125 degrees (F), 09/05/23 128 degrees (F), 09/06/23 130 degrees (F), 09/07/23 126 degrees (F), 09/08/23 130 degrees (F), 09/11/23 126 degrees (F), 09/12/23 124 degrees (F), 09/13/23 121 degrees (F) , 09/18/23 130 degrees (F), 09/19/23 126 degrees (F), 09/20/23 124 degrees (F), 09/21/23 120 degrees (F), 09/29/23 130 degrees (F) October 2023 10/02/23 125 degrees (F), 10/03/23 130 degrees (F), 10/04/23 132 degrees (F), 10/05/23 130 degrees (F) 10/09/23 140 degrees (F), 10/10/23 138 degrees (F), 10/11/23 10/13/23 130 degrees (F), 10/16/23 120 degrees (F), 10/17/23 130 degrees (F), 10/18/23 124 degrees (F), 10/19/23 124 degrees (F),10/20/23 128 degrees (F), 10/24/23 132 degrees (F), 10/25/23 128 degrees (F), 10/26/23 130 degrees (F), 10/27/23 142 degrees (F), 10/30/23 140 degrees (F), 10/31/23 132 degrees (F) November 2023 11/01/23 128 degrees (F), 11/02/23 132 degrees (F), 11/03/23 141 degrees (F), 11/06/23 140 degrees (F), 11/07/23 128 degrees (F), 11/08/23 130 degrees (F), 11/09/23 134 degrees (F), 11/13/23 130 degrees (F), 11/14/23 126 degrees (F), December 2023 12/01/23 130 degrees (F), 12/04/23 130 degrees (F), 12/05/23 132 degrees (F), 12/06/23 140 degrees (F), 12/07/23 128 degrees (F), 12/08/23 132 degrees (F), 12/11/23 130 degrees (F), 12/12/23 126 degrees (F), 12/13/23 140 degrees (F), 12/14/23 140 degrees (F), 12/15/23 138 degrees (F), 12/20/23 130 degrees (F), 12/21/23 126 degrees (F), 12/22/23 140 degrees (F), 12/26/23 128 degrees (F), 12/28/23 132 degrees (F), 12/29/23 130 degrees (F) January 2024 Record review revealed water temperatures continued to be above 110 degrees (F) on 01/05/24, 01/06/24, and on 01/07/24. These temperatures logs revealed temperateurs were taken at four (4) sinks, and in the shower room. h) Education of staff During the night of 01/04/24 into 01/05/24 the ADON educated the night shift staff that temperatures that exceed 110 degrees were not within regulation and should not be used on any resident. The staff included RN #100, Nurse Aid #99, # 41, #59, #63, #60 and #85. i) Maintenance Director Inservice On 01/06/24 at 12:20 PM the Maintenance Director and maintenance staff was in -serviced the Maintenance staff as follows: Anytime the water Temp is Above 110 you must notify the charge nurse that the hot water is not to be used in that specific area and make corrections. You must document when notification was made and to whom. Typed as written. (continued on next page)

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	51E148	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	j) Nurse Educator (NE) #78 An email from the nurse educator to administrative staff dated 01/07/24 at 9:54 AM revealed NE #78 was still concerned about the hot water in the sinks. In the email the nurse educator explains that the staff had been told not to use the hot water because it had been registering over 110 degrees (F). The nurse educator stated she was concerned that residents would use the sink and nursing could not monitor the situaiton. In her email the Nurse Educator said that Licensed Practical Nurse (LPN) #46 had asked about shutting the hot water off and was told it could not be done. Record review revealed the nursing home administartor gave an order and the hot water was shut off at 6:54 PM on 01/07/24. k) Quality Assurance and Performance Improvement (QAPI) Evidence provided by the QA-QAPI RN on 01/09/24 stated that this was the first rough draft of events involving hot water that resulted in third degree burns to Resident #19. Resident #19 was transferred to the emergency room and is currently not residing in (name of facility). All residents have the potential to be affected. On 01/05/24, DON conducted a skin assessment of all residents which revealed no other residents to have evidence of burns. On 01/04/24 the maintenance director placed the identified whirlpool (tub) out of service and investigated what may have caused the increased hot water temperature in the tub during the incident. The investigation revealed a malfunctioning hot water tank thermostat, which was immediately replaced by the maintenance director/maintenance staff on 01/04/24. On 01/05/24, the QAPI team instituted a more frequent monitoring of hot water temperatures, every hour and to prevent resident use of hot water above 110 degrees. Additionally, on 01/05/24, the QAPI stopped all showers and tub baths until hot water could be restored to no higher than 110 degrees. The administrator on 01/07/24 directed maintenance staff to physically shut off all hot water access by residents as an added precaution pending further maintenance evaluation/repairs to the hot water system. On 01/05/24, the QAPI team instituted temperature checks of hot water outlets on the resident units, to be completed each hour. Temperatures found to be greater than 110 degrees, were to be reported immediately to the administrator, residents were to be prevented from using the identified outlet(S), and mechanical adjustments made to the hot water system in order to bring temperatures below 110 Fahrenheit. On 01/08/24, due to residents no longer having access/exposure to hot water outlets, the QAPI team modified the monitoring of hot water temperatures to an as needed basis due to repairs actively being made to the hot water system, until further. (continued on next page)

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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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Quality Assurance and Performance Improvement Committee (QAPI) met on 01/09/24 at 10:00 AM to discuss the current situation of water temps for resident care. Documentation revealed that water temps were being checked every hour since 01/05/24 at the four (4) main sinks on Resident corridors of A1 and B1 and the resident showers on the corridors of A1 and [NAME] 1, with this documentation forwarded to Administration for review. The showers have not been used since 01/04/24. Repairs were initiated on the hot water system on 01/08/24 to isolate the hot water distributed to the resident care areas and residents currently have no access to hot water until the final repairs are made. Prior to the time of survey, potential mechanical issues with an isolation valve, hot water tank thermostat, and a water system distribution mixing valve and gauge were discovered. The isolation valve, thermostat, and mixing valve gauge had been replaced prior to the survey. The water system distribution mixing valve was being investigated further with parts being ordered for repair during the survey. Nursing staff were notified that they would be using wipes and no rinse shampoo and body wash until further notice. Per the QAPI meeting minutes, reeducation was provided to staff reiterating appropriate hot water temperatures and completing maintenance work orders if issues are suspected with the temperature of the water system. l) Phone interview on 01/09/24 at 11:36 AM., with the Director of Facilities and Plant Operations #97 revealed that the perceived issue with the hot water system was a faulty thermostat on the hot water tank serving resident corridors A1 and B1 of the Nursing Building. The issue with the thermostat was believed to have failed in the close position and was discovered mid-morning on Friday, January 5th. The hot water system was drained and refilled with 55-degree city water. An isolation valve was added on Monday, January 8th. Employee #97 also noted that hot water temperatures were not supposed to be above 110 degrees. m) An observation on 01/09/24 at 12:14 PM, revealed that the only hot water being provided to the resident areas was to the Dining Area. The temperature of the hot water as recorded at a hand sink in the Dining area was noted as 109.1. Hot water to the other resident areas such as Corridor A1, B1, and [NAME] 1 was isolated off in the basement and handles removed from faucets and fixtures to prevent residents from accidentally turning on the hot water while repairs and adjustments were made to the system. n) Building Maintenance Mechanic (BMM)#95 An interview on 01/09/24 at 1:03 PM, with BMM #95 revealed that an issue with a thermostat on a hot water tank in the basement (Potato Room) was discovered and replaced. A ball valve was also replaced as a suspected back-feed elimination. A gauge for the mixing valve for the water leaving this area to the resident areas was also replaced. Employee #95 noted that a daily log of the water temperatures was maintained in each mechanical room. In addition, Employee #95 stated that he was not aware that temperatures above 110 degrees needed to be reported and only recorded what the gauges read and was not previously aware of what the water temperatures were supposed to be maintained at. o) Building Maintenance Mechanic (BMM) #14An interview on 01/09/24 at 1:15 PM, with Building Maintenance Mechanic #14 revealed that he was off work during the time of noted issues with the water system and had just returned to work on the morning of Monday, January 8th. Employee #14 noted that he was not aware that any issues with the noted water temperatures needed to be reported to anyone. (continued on next page)

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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 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	p) Maintenance Supervisor (MS) #76 During a phone interview on 01/10/24 at 9:43 AM, the Maintenance Supervisor (MA) #76 noted that he had been the Maintenance Supervisor for approximately five (5) years.MS #76 noted that he recorded the temperatures of the hot water system as noted on the gauges and seemed to be aware that the temperatures were supposed to be maintained at 110 degrees. He also noted that he tried to keep temperatures warm enough on the floors as Nursing would let him know if the temperatures s#76 noted that he did not report the daily/monthly temperature logs to any committee or had not been asked for them. q) Preventive Maintenance and Caualty Prevention Plan The Office of Health Facilities Policy (Policy OHF.LS.0002) for Preventive Maintenance and Casualty Prevention Plan has been updated to include an effective date based upon the date of approval on the signature page. This policy outlines the testing and preventative maintenance procedures and documentation requirements for the Plant Operations, Maintenance, and Engineering Staff. Documentation from the Preventative Maintenance and Casualty Prevention Plan is monitored through safety surveillance, which is conducted hospital wide monthly by members of the Safety Committee. These inspection reports are to be given to the Safety Officer, who will then assign corrective action from the appropriate department. This policy outlines that all boiler room equipment gauges are to be visually monitored daily and that patient hot water is not to exceed 110 degrees (F) with any deviations reported to the Maintenance Department immediately.

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37324 Based on observation, record review, and staff interview the licensee failed to maintain hot water mechanical equipment in safe operating condition. According to CMS guidelines exposure at water temperature of 133 degrees Fahrenheit (F) can lead to third degree burns in 15 seconds. Resident #19 was bathed in 134 degrees (F) water. Resident #19 sustained second degree burns to the left hand, bilateral lower extremeties, bilateral buttocks, and scrotum. The staff responsible for monitoring water temperatures and maintaining equipment knew the hot water had measured more than 110 degrees (F) since January 2023. This caused an immediate jeopardy situation that began on 01/03/23 and ended on 01/07/24. This practice had the potential to affect all facility residents. Resident identifier: #19. Facility census 44. Findings included: a) Facility Reported Incident A facility reported incident was received at the state agency on 01/05/24. The report stated Nurse Aide #99 put Resident #19 into a whirlpool tub. She filled the tub to the knee level. The nurse aide realized the water was too warm. She had another aide try to adjust the water. The nurse aide admitted to not looking at the water temperature and this resulted in Resident #19 receiving severe burns to lower legs, feet, thigh, and left hand. The facility reported the immediate action taken was to suspend the nurse aide, take all tubs out of service and check for malfunction. Adult protective services were notified, the ombudsman, the local sheriff's department, and the nurse aide registry. A second facility reported incident dated 01/04/24 related to Resident #19 was also received by the state agency. This incident stated the registered nurse (RN #100) did not assess or treat a resident with severe burns timely. The immediate action taken was a suspension of the registered nurse in addition to the nurse aide and a shutdown of the bathtubs. A third facility reported incident dated 01/05/24 was sent to the state agency. This incident stated Maintenance Supervisor (MS) #76 had been monitoring water temperatures for over six (6) months that did not meet regulatory guidelines. MS #76 failed to report the temperatures or attempt to make any changes to meet regulatory compliance. The report revealed MS #76 said he was aware of the guidelines for water temperature and chose to keep it warmer per staff request. The five (5) day follow up report obtained on 01/09/24 revealed the following: After reviewing camera and interviewing staff (Registered Nurse #100) was asked by CNA (ceritfied nurse assistant) that was giving (Resident #19) his bath to assess him. Another CNA asked nurse to assess him. Finally at 7:36 she went to shower room and left at 7:37. At 8:44 she got order to send to ER (emergency room). No 1st aide administered by unit nurse until 9:05. Nurse (Registered Nurse #100) sent home until investigation over. (Registered Nurse #100) failed to assess (Resident #19) when asked 3 times by CNAs. Did not administer treatment in a timely manner. I find this report to be substantiated for neglect of resident. (Registered Nurse #100) will be removed from schedule and her agency will be notified of decision. Excessive delay in treatment. (continued on next page)

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Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This report was completed by the social service supervisor. A five day follow up to the immediate report for Certified Nurse Aide (NA) #41 revealed: After reviewing camera and interviewing NA #41 who was called to shower room and found the water too hot and adjusted water temperature. She was seen on camera leaving the shower room and going to nurses station but camera has no sound. I find this to be substantiated. NA #41 did adjust water but failed to assist in maintaining safety of resident. NA #41 sent home until investigation is done. I find this report to be substantiated for neglect of resident. NA #41 will be removed from schedule and her agency will be notified of decision. This report was completed by the social service supervisor. b) Entrance by State Agency During the entrance conference with the Assistant Nursing Home Administrator (ANHA) and the DON, on 01/09/24 at 12:25 PM, the DON stated Resident (#19) had received third degree burns to both lower extremities during a tub bath on the evening of 01/04/24. They said the resident had been transferred to a local hospital and then transferred to an out of state burn unit. Hospital records revealed the resident had second degree burns to bilateral lower extremities, the left hand, bilateral buttocks, and scrotum. The hospital report reflected the resident was burned an estimated 35% of his body. c) Facility provided hot water temperature logs from the mixing valve January 2023 01/03/23 122 degrees (F), 01/04/23 120 degrees (F), 01/05/23 118 degrees (F), 01/06/23 124 degrees (F), 01/09/23 120 degrees (F), 01/10/23 126 degrees (F), 01/11/23 122 degrees (F), 01/12/23 120 degrees (F), 01/15/23 120 degrees 126 degrees (F), 01/18/23 124 degrees (F), 01/19/23 122 degrees (F), 01/20/23 120 degrees (F), , 01/24/23 126 degrees (F), 01/25/23 122 degrees (F), 01/26/23 126 degrees (F), 01/27/23 124 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), February 2023 02/02/23 124 degrees (F), 02/03/23 124 degrees (F), 02/06/23 126 degrees (F), 02/07/23 124 degrees (F), 02/08/23 130 degrees (F),02/13/23 126 degrees (F), 02/14/23 124 degrees (F), 02/15/23 128 degrees (F), 02/16/23 126 degrees (F), 02/17/23 128 degrees (F), 02/21/23 124 degrees (F), 02/22/23 128 degrees (F), 02/23/23 126 degrees (F), 02/24/23 128 degrees (F), 02/27/23 120 degrees (F) March 2023 03/01/23 126 degrees (F), 03/02/23 120 degrees (F), 03/03/23 124 degrees (F), 03/06/23 130 degrees (F), 03/07/23 124 degrees (F), 03/08/23 126 degrees (F), 03/09/23 126 degrees (F), 03/10/23 130 degrees (F), 03/16/23 120 degrees (F), 03/20/23 130 degrees (F), 03/21/23 130 degrees (F), 03/22/23 119 degrees (F), 03/23/23 124 degrees (F) 03/27/23 124 degrees (F), 03/28/23 128 degrees (F) April 2023 (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	04/03/23 120 degrees (F), 04/04/23 126 degrees (F), 04/05/23 124 degrees (F), 04/06/23 119 degrees (F), 04/07/23 121 degrees (F), 04/10/23 120 degrees (F), 04/11/23 124 degrees (F), 04/12/23 123 degrees (F), 04/13/23 121 degrees (F), 04/14/23 115 degrees (F), 04/17/23 125 degrees (F), 04/18/23 120 degrees (F), 04/19/23 119 degrees (F), 04/20/23 121 degrees (F), 04/21/21 122 degrees (F), 04/24/23 130 degrees (F), 04/25/23 128 degrees (F), 04/26/23 115 degrees (F), 04/28/23 120 degrees (F) May 2023 05/01/23 120 degrees (F), 05/02/23 124 degrees (F), 05/03/23 122 degrees (F), 05/04/23 122 degrees (F), 05/05/23 118 degrees (F), 05/10/23 116 degrees (F), 05/11/23 124 degrees (F), 05/15/23 120 degrees (F), 05/16/23 126 degrees (F), 05/17/23 130 degrees (F), 05/18/23 120 degrees (F), 05/19/23 118 degrees (F), 05/22/23 122 degrees (F), 05/23/23 120 degrees (F), 05/24/23 116 degrees (F), 05/26/23 130 degrees (F), 05/29/23 130 degrees (F), 05/30/23 120 degrees (F), 05/31/23 124 degrees (F) June 2023 06/01/23 120 degrees (F), 06/02/23 112 degrees (F), 06/05/23 120 degrees (F), 06/06/23 116 degrees (F), 06/07/23 120 degrees (F), 06/08/23 130 degrees (F), 06/09/23 130 degrees (F), 06/12/23 118 degrees (F), 06/13/23 126 degrees (F), 06/14/23 122 degrees (F), 06/15/23 124 degrees (F), 06/16/23 118 degrees (F), 06/19/23 121 degrees (F), 06/20/23 114 degrees (F), 06/21/23 120 degrees (F), 06/22/23 122 degrees (F), 06/23/24 116 degrees (F), 06/26/23 131 degrees (F), 06/27/23 122 degrees (F), 06/28/23 124 degrees (F), 06/29/23 120 degrees (F), 06/30/23 124 degrees (F) July 2023 07/05/23 121 degrees (F), 07/06/23 120 degrees (F), 07/07/23 120 degrees (F), 07/10/23 121 degrees (F), 07/11/23 116 degrees (F), 07/14/23 120 degrees (F), 07/17/23 122 degrees (F), 07/18/23 132 degrees (F), 07/19/23 124 degrees (F), 07/20/23 114 degrees (F), 07/21/23 128 degrees (F),07/26/23 120 degrees (F), 07/27/23 118 degrees (F), 07/28/23 122 degrees (F), 07/31/23 120 degrees (F) August 2023 08/01/23 120 degrees (F), 08/02/23 118 degrees (F), 08/03/23 120 degrees (F), 08/04/23 124 degrees (F), 08/07/23 120 degrees (F), 08/08/23 121 degrees (F), 08/09/23 118 degrees (F), 08/10/23 122 degrees (F), 08/11/23 130 degrees (F), 08/14/23 121 degrees (F), 08/15/23 129 degrees (F), 08/16/23 118 degrees (F), 08/18/23 136 degrees (F), 08/21/23 120 degrees (F), 08/22/23 124 degrees (F), 08/23/23 133 degrees (F), 08/24/23 114 degrees (F), 08/25/23 126 degrees (F), 08/28/23 130 degrees (F), 08/29/23 140 degrees (F), 08/30/23 128 degrees (F), September 2023 09/01/23 125 degrees (F), 09/05/23 128 degrees (F), 09/06/23 130 degrees (F), 09/07/23 126 degrees (F), 09/08/23 130 degrees (F), 09/11/23 126 degrees (F), 09/12/23 124 degrees (F), 09/13/23 121 degrees (F) , 09/18/23 130 degrees (F), 09/19/23 126 degrees (F), 09/20/23 124 degrees (F), 09/21/23 120 degrees (F), 09/29/23 130 degrees (F) (continued on next page)

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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 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	October 2023 10/02/23 125 degrees (F), 10/03/23 130 degrees (F), 10/04/23 132 degrees (F), 10/05/23 130 degrees (F) 10/09/23 140 degrees (F), 10/10/23 138 degrees (F), 10/11/23 10/13/23 130 degrees (F), 10/16/23 120 degrees (F), 10/17/23 130 degrees (F), 10/18/23 124 degrees (F), 10/19/23 124 degrees (F),10/20/23 128 degrees (F), 10/24/23 132 degrees (F), 10/25/23 128 degrees (F), 10/26/23 130 (F) degrees (F), 10/27/23 142 degrees (F), 10/30/23 140 degrees (F), 10/31/23 132 degrees (F) November 2023 11/01/23 128 degrees (F), 11/02/23 132 degrees (F), 11/03/23 141 degrees (F), 11/06/23 140 degrees (F), 11/07/23 128 degrees (F), 11/08/23 130 degrees (F), 11/09/23 134 degrees (F), 11/13/23 130 degrees (F), 11/14/23 126 degrees (F), December 2023 12/01/23 130 degrees (F), 12/04/23 130 degrees (F), 12/05/23 132 degrees (F), 12/06/23 140 degrees (F), 12/07/23 128 degrees (F), 12/08/23 132 degrees (F), 12/11/23 130 degrees (F), 12/12/23 126 degrees (F), 12/13/23 140 degrees (F), 12/14/23 140 degrees (F), 12/15/23 138 degrees (F), 12/20/23 130 degrees (F), 12/21/23 126 degrees (F), 12/22/23 140 degrees (F), 12/26/23 128 degrees (F), 12/28/23 132 degrees (F), 12/29/23 130 degrees (F) January 2024 Record review revealed water temperatures continued to be above 110 degrees (F) on 01/05/24, 01/06/24, and on 01/07/24. These temperatures logs revealed temperatures were taken at four (4) sinks, and in the shower room. Record review on 01/09/24 at approximately 2:18 PM, revealed no documentation to show the corrective action or adjustments to the resident hot water system when water temperatures were routinely recorded above 110 degrees Fahrenheit from January 2023 through December 2023 by the Maintenance Department Staff. The water supplied resident corridors A1, B1, and Shower Room ([NAME]) and Dining Room ([NAME]). An interview on 01/09/24 at approximately 2:20 p.m. with the Assistant Administrator verified this finding. d) Maintenance Supervisor (MS) #76 Phone interview on 01/10/24 at approximately 9:43 AM, with MS #76 noted he had been the MS for approximately five (5) years. Interview revealed he recorded the temperatures of the hot water system as noted on the gauges and seemed aware the temperatures were supposed to be maintained at 110 degrees (F). He also said he tried to keep temperatures warm enough on the floors. He said nursing would let him know if the temperatures seemed too cold. The interview with MS #76 noted that he did not report the daily/monthly temperature logs to any committee. Furthermore, he said he had not been asked for these records by any of the reporting committees, such as the Safety Committee or the Quality and Performance Improvement (QAPI) Committee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E148	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review, on 01/10/24 at 12:37 PM, of Preventative Maintenance and Casualty Prevention Plan revealed that Safety Surveillance was conducted hospital wide monthly by members of the Safety Committee. Reports of inspection are given to the Safety Officer who will then assign the deficiency correction to the proper department for action. Per the Preventative Maintenance and Casualty Prevention Plan these reports and corrective action documents are also attached to the master copy of the Quality Committee minutes. Record review revealed no documentation provided during the survey to show that Safety Surveillance was reported to the Quality and Performance Improvement (QAPI) Committee from July 2023 through December 2023, as outlined in the Preventative Maintenance and Casualty Prevention Plan. On 01/10/24 at 1:10 PM during an interview the assistant administrator and the administrator confirmed they had not looked at the hot water temperatures being recorded by the maintenance employee, nor had they checked to see if any preventative maintenance was being done to the hot water equipment. e) Resident #19 Record review revealed Resident #19 was admitted to the facility 10/12/17. Medical diagnoses included dementia with behavioral disturbances, unspecified psychosis not due to a substance or known physiological condition, peripheral vascular disease (PVD), alcohol dependence in remission, Fabry's disease, and high blood pressure. No Brief Interview for Mental Status (BIMS) was able to be obtained as the only verbal response was grunting. f) Nurse Educator (NE) #78 An email from the nurse educator to administrative staff dated 01/07/24 at 9:54 AM revealed NE #78 was still concerned about the hot water in the sinks. In the email the nurse educator explains that the staff had been told not to use the hot water because it had been registering over 110 degrees (F). The nurse educator stated she was concerned that residents would use the sink and nursing could not monitor the situation. In her email the Nurse Educator said that Licensed Practical Nurse (LPN) #46 had asked about shutting the hot water off and was told it could not be done. Rercord review revealed the Nursing Home Administrator gave an order for the hot water to be shut off at 6:54 PM on 01/07/24. g) Maintenance Director In service On 01/06/24 at 12:20 PM the Maintenance Director and maintenance staff was in -serviced. The in-service included: Anytime the water Temp is Above 110 you must notify the charge nurse that the hot water is not to be used in that specific area and make corrections. You must document when notification was made and to whom. Typed as written. On 01/11/24 at 10:40 AM, in the presence of the Director of Nursing (DON), NA #66 was interviewed. NA #66 stated she showed new employees how to operate the tub and then had the new employee complete a return demonstration. When asked how this was documented, CNA #66 stated, We used to have one (skills competency check off sheet) but I don't have one now. h) Quality Assurance and Performance Improvement (QAPI) (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Evidence provided by the QA-QAPI RN on 01/09/24 stated that this was the first rough draft of events involving hot water that resulted in third degree burns to Resident #19. Resident #19 was transferred to the emergency room and is currently not residing in (name of facility). All residents have the potential to be affected. On 01/05/24, DON conducted a skin assessment of all residents which revealed no other residents to have evidence of burns. On 01/04/24 the maintenance director placed the identified whirlpool (tub) out of service and investigated what may have caused the increased hot water temperature in the tub during the incident. The investigation revealed a malfunctioning hot water tank thermostat, which was immediately replaced by the maintenance director/maintenance staff on 01/04/24. On 01/05/24, the QAPI team instituted a more frequent monitoring of hot water temperatures, every hour and to prevent resident use of hot water above 110 degrees. Additionally, on 01/05/24, the QAPI stopped all showers and tub baths until hot water could be restored to no higher than 110 degrees. The administrator on 01/07/24 directed maintenance staff to physically shut off all hot water access by residents as an added precaution pending further maintenance evaluation/repairs to the hot water system. The plan of correction supported this. On 01/05/24, the QAPI team instituted temperature checks of hot water outlets on the resident units, to be completed each hour. Temperatures found to be greater than 110 degrees, were to be reported immediately to the administrator, residents were to be prevented from using the water. The facility's hot water temperatures were recorded above 110 degrees Fahrenheit monthly from January 2023 through December 2023. However, the facility had established procedures and monitoring processes to address the self-reported issues with the hot water system. i) The Quality Assurance and Performance Improvement Committee (QAPI) met on 01/09/24 at 10:00 AM to discuss the current situation of water temps for resident care. Documentation revealed that water temps were being checked every hour since 01/05/24 at the four (4) main sinks on Resident corridors of A1 and B1 and the resident showers on the corridors of A1 and [NAME] 1, with this documentation forwarded to Administration for review. The showers have not been used since 01/04/24. Repairs were initiated on the hot water system on 01/08/24 to isolate the hot water distributed to the resident care areas and residents currently have no access to hot water until the final repairs are made. Prior to the time of survey, potential mechanical issues with an isolation valve, hot water tank thermostat, and a water system distribution mixing valve and gauge were discovered. The isolation valve, thermostat, and mixing valve gauge had been replaced prior to the survey. The water system distribution mixing valve was being investigated further with parts being ordered for repair during the survey. Nursing staff were notified that they would be using wipes and no rinse shampoo and body wash until further notice. Per the QAPI meeting minutes, reeducation was provided to staff reiterating appropriate hot water temperatures and completing maintenance work orders if issues are suspected with the temperature of the water system. (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Phone interview on 01/09/24 at 11:36 AM., with the Director of Facilities and Plant Operations (Employee #97) revealed that the perceived issue with the hot water system was a faulty thermostat on the hot water tank serving resident corridors A1 and B1 of the Nursing Building. The issue with the thermostat was believed to have failed in the close position and was discovered mid-morning on Friday, January 5th. The hot water system was drained and refilled with 55-degree city water. An isolation valve was added on Monday, January 8th. Employee #97 also noted that hot water temperatures were not supposed to be above 110 degrees. An observation on 01/09/24 at 12:14 PM revealed that the only hot water being provided to the resident areas was to the Dining Area. The temperature of the hot water recorded at a hand sink in the Dining area was noted as 109.1. Hot water to the other resident areas such as Corridor A1, B1, and [NAME] 1 was isolated in the basement and handles removed from faucets and fixtures to prevent residents from accidentally turning on the hot water while repairs and adjustments were made to the system. An interview on 01/09/24 at 1:03 PM, with the Building Maintenance Mechanic (BMM) #95 revealed that an issue with a thermostat on a hot water tank in the basement (Potato Room) was discovered and replaced. A ball valve was also replaced as a suspected back-feed elimination. A gauge for the mixing valve for the water leaving this area to the resident areas was also replaced. BMM #95 noted that a daily log of the water temperatures was maintained in each mechanical room. In addition, BMM #95 stated he was not aware that temperatures above 110 degrees needed to be reported and only recorded what the gauges read and was not previously aware of what the water temperatures were supposed to be maintained at. An interview on 01/09/24 at 1:15 PM, with Building Maintenance Mechanic (BMM) #14 revealed that he was off from work during the time of noted issues with the water system and had just returned to work on the morning of Monday, January 8th. BMM#14 noted that he was not aware that any issues with the noted water temperatures needed to be reported to anyone. During a phone interview on 01/10/24 at 9:43 AM, the Maintenance Supervisor (MS) #76 said he had been the MS for approximately five (5) years. MS #76 noted that he recorded the temperatures of the hot water system as noted on the gauges and seemed to be aware that the temperatures were supposed to be maintained at 110 degrees. He also noted that he tried to keep temperatures warm enough on the floors as Nursing would let him know if the temperatures seemed too cold. Employee #76 noted that he did not report the daily/monthly temperature logs to any committee or had not been asked for them.