Printed: 06/27/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIE Hopemont Hospital	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	(X3) DATE SURVEY COMPLETED 02/09/2024 P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact 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	and neglect by anybody.  **NOTE- TERMS IN BRACKETS IN	eived at the state agency on 01/04/24. Dool tub. She filled the tub to the knee lether aide try to adjust the water. The nutled in Resident #19 receiving severe the immediate action taken was to sustiction. Adult protective services were nother nurse aide registry.  In the nurse aide registry.  In the determinant of the registered nurse in a suspension of the regi	onfidentiality** 30153  re log review, and facility reportable ensure one (1) of six (6) residents F). This failure resulted in physical fit hand, bilateral lower extremities ardy situation that began on on 01/07/24 at 6:54 PM when all hot sted by the hot water temperatures.  The report stated Nurse Aide (NA) wel. The nurse aide realized the urse aide admitted to not looking at burns to lower legs, feet, thighs, pend the nurse aide, take all tubs otified, as well as, the ombudsman, as was also received by the state a resident with severe burns timely, addition to the nurse aide and a ncy. This incident stated tes for over six (6) months which did for attempt to make any changes to

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 51E148

If continuation sheet Page 1 of 40

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILLTIDLE CONCTRUCTION	(YZ) DATE CURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	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, ZI	P CODE	
Hopemont Hospital		150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0600	The five (5) day follow up report ob	tained on 01/09/24 revealed the follow	ing:	
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 (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	al service supervisor.		
	A five day follow up to the immedia	te 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			
	disturbances, unspecified psychosi vascular disease (PVD), alcohol de Brief Interview for Mental Status (B The resident was incontinent of box	Resident #19 was admitted to the facility 10/12/17. Medical diagnoses included dementia with behavioral isturbances, unspecified psychosis not due to a substance or known physiological condition, peripheral ascular 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 erved as health care surrogate for this resident.		
	d) Timeline			
	A timeline provided by the facility reby Nurse Aide (NA) #99.	evealed Resident #19 was taken to the	tub room on 01/04/24 at 7:12 PM	
		w of the videotape of the hallway activi MDS) Coordinator. This video was on 0		
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI	P CODE	
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.		ogonov		
	, , , , , , , , , , , , , , , , , , ,	<u> </u>	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0600	7:12 PM Resident #19 was taken to the tub room by Nurse Aide (NA) #99.			
Level of Harm - Immediate jeopardy to resident health or	7:16 PM NA #99 out in the hall time	es two (2) and back to the tub room.		
safety	7:17 PM NA #99 out of the tub roor	n-went to Resident #19's room and ret	urned to the tub room.	
Residents Affected - Many	7:20 PM NA #99 to Nurses Station room.	(NS) then part way up hall got NA #41	and together they went to the tub	
	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 to	ub 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 re	eturns to Resident #19's room.	
	(continued on next page)			

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NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive Terra Alta, WV 26764	
For information on the nursing home's	plan to correct this deficiency, please con	I tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	8:33 PM NA #63 leaves Resident # 8:38 PM NA #63 to NS and then to 8:40 PM NA #59 to the tub room ar 8:41 PM NA #63 and #59 return to 8:42 PM NA #59 goes down B1 hal 8:43 PM NHA (nursing home adminthen to Resident #19's room.  A review of a nursing progress note PM to the local hospital. Resident # and calves.  Vitals were documented from three Temperature: 97.7 (36.5 C) (01/04/ Pulse 55 (01/04/2024 17:53 (5:53 F Respiration: 18 (01/04/2024 17:53 Blood Pressure: 127/66 (01/04/202 e) Investigation Statements  -HSW (health service worker) #99 Statement dated 01/04/24 as follow I was giving resident B110b (#19) a on the back of his foot. I then went come look at it shortly. I waited a fe other aide on the hall (name of aide to come look at it now. The nurse of next. (see whether he'd need to be names) transferred him to his whee do, then took him to his room, got h blistering. Typed as written.  -HSW #41	Resident #19's room.  If then returns to Resident #19's room.  If the part #100 revealed the resident was #19 was documented to have blistering  If the part #100 revealed the resident was #19 was documented to have blistering  If the part #100 revealed the resident was #19 was documented to have blistering  If then returns to Resident #19's room.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the part #100 revealed the resident was form.  If the	oes to the tub room then NS and stransferred on 01/04/24 at 9:15 and peeling skin to bilateral feet and peeling skin to bilateral feet experience in the stransferred on 01/04/24 at 9:15 and peeling skin to bilateral feet experience in the stransferred on the stransf
	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.		
	thought his feet looked bad and the went to the tub room to look at ther his shin (left). After I seen them I w She said Why do they look bad? I t room to see his feet when she saw the problem. The nurse then said s was from the water and those were left in the empty tub for awhile after because he was ripping his skin off rubbing them on the drain. We put	tet me to see if I could get the nurse to be nurse to her she would look at them we mand seen they were badly blistered of the nurses station to tell the nurse told her no you want to come now. The the she asked if Resident #19 had educe the will go check the computer to see if the burns because it looked like his skin were and I decided he needed to be moved if his legs by rubbing them together and him to be and placed wet rags on his be we what was going to happen. Stayed we	when he got back into bed. So I in the top and sides and a blister on the she needed to come look at him. In the tub the sma? I told her yes, but that 'not day shift reported it. I told her it was melting off. Resident #19 was I to his room via w/c (wheel chair) ripping the skin off his feet by urns and stayed with him trying to
	I arrived at Hopemont once being r (last name) RN #100 was at the nu went to his room and CNA staff addiffrst name) #19 was burned and sh while in the tub and left the bathroot Resident #19 and stated he is in of nurse never came to his room. My addressing this issue were implement thoroughly. I went to the nurses stated pain management now. I as the doctor. I told her something newsent out and that it was almost 30 mesident and his care needs.  I helped interview her with the socials a long term RN and having works.	A) statement on 01/09/24 at 10:04 AM.  made aware of this issue of the burn. It is is station. She said to me (Resident vised they repeatedly told (RN first name needed to look at him. They said she om. They got him out of the tub and too ovious discomfort and pain that needs to involvement and goal was to see that a sented to identify, correct, process, and ation after watching the resident writhing ked if she had been to his room. She sided to be done now. Further I learned to minutes before RN #100 even called 9 and worker. She excused her action on the ked here before she was well aware of ed and that emergency care is immediated.	first name) #19 is in his room. I he RN #100 that resident (resident only momentarily observed him k him to his room. I observed o be addressed. They stated the appropriate steps regarding investigate the matter fully and g in pain. I advised RN #100 he had no and asked if she should call that the doctor ordered the resident 1. She in no way assessed the raining and orientation. I explained the process, care responsibility,

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED	
	51E148	B. Wing	02/09/2024	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	This nurse was at nurses desk whe (Resident #19) feet normally peel. later and asked nurse to come and about 1 inch red and feet were red, numbers to try and contact on call. immediate. Got on call number from On call supposed to re-contact. Co large and redness moving up his lee Contacted back by phone and seven 911 and gave report. Contacted MI med. Paper work put together and date nor times when this statement resident assessments completed.  A review of of nursing progress not PM) found the following:  The resident left the facility on [DAT blistering and peeling skin to bilater Registered Nurse (RN) #100 on 01  Vitals at Time of Transfer:  Temperature: 97.7 (36.5 C) (01/04/2024 17:53  Respirations: 18 (01/04/2024 17:53  Blood Pressure: 127/66 (01/04/2024 17:53  Blood Pressure: 127/66 (01/04/2024 17:53)  A nursing note dated 01/05/24 at 1 MD order for evaluation and treatm resident was in the bath and when The note stated that the on call nur and an order to send the resident comouth previous to EMT arriving at the resident at 9:15 PM by ambulance  The resident's general condition was for feeding. The resident moved all	en first CNA came out to desk from sho Told CNA I would check on it. Other CN assess residents feet. This nurse wen blistering and starting to peel. Attempt There was no answer. Attempted to m another staff and (unable to determinated MD for order to send out after ags. Delay in call back from on call. MD eral minutes later contacted by ADON. D back as ADON arrived and went to set was to when it was written and no time as titled Nursing transfer/Discharge Notes are titled Nursing transfer/Discharge Notes are titled Nursing transfer note descrated feet and calves. The transfer note w/04/24 at 8:49 PM.  (2024 17:53 (5:53 PM)  PM)  (3 (5:53 PM)  (4 17:53 (5:53 PM)  (5:53 PM)  (5:53 PM)  (6)  (6)  (7)  (6)  (7)  (7)  (8)  (8)  (8)  (9)  (9)  (9)  (9)  (9	ower room and asked if resident's NA approached several minutes to assess feet. Lower part of legs ted to contact A! to get phone essage on call but reply not the this word). Informed of situation. Second assessment with blisters gave permission to send out. Called the resident to get order for pain ned by RN #100. There was no tes when calls were made or the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the resident as having the resident as having the resident as the r	
	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 purse was notified at 7:59 PM and the Medical Director (MD) was contacted			
	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			
	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 incontine 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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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Hopemont Hospital 150 Hopemont Drive Terra Alta, WV 26764			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety	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.		
Residents Affected - Many	A report from the local hospital where the resident was transferred revealed the resident had second deg burns to bilateral lower extremities and feet, left hand, bilateral buttocks and scrotum. The estimated surfarea 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
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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	Ensure that a nursing home area is accidents.  **NOTE- TERMS IN BRACKETS H Based on observation, staff intervieincident (FRI) review, and hospital an environment which was as free monitor the water temperature whe the bathing process. After Resident tub. Resident #19 sustained second bilateral buttocks and scrotum. This PM when the resident was placed in the facility was turned off. When the Resident identifier: #19. Facility cer Findings included:  a) Facility Reportable Incident (FRI A facility reported incident was rece #99 put Resident #19 into a whirlpowater was too warm. She had anoth the water temperature and this result and left hand. The facility reported out of service and check for malfund the local sheriff's department, and the local sheriff's department, and the immediate action taken was a shutdown of the bathtubs.  A third facility reported incident date had been monitoring water temperature was #76 failed to report the temperature per staff request.	AVE BEEN EDITED TO PROTECT Columns, medical record review, temperature record review, the facility failed to ensure of accident hazards as was possible. In filling the tub. In addition NA #99 failed the tub, water at 13 did degree burns to the left hand, bilaterals created an immediate jeopardy situation the water and it ended on 01/07/24 are immediate jeopardy was removed the insus: 44.	les adequate supervision to prevent  ONFIDENTIALITY** 30153  e log review, facility reportable fre one (1) of six (6) residents had furse Aide (NA) #99 failed to ed to supervise this resident during 84 degrees (F) was used to fill the al lower extremities and feet, ion that began on 01/04/24 at 7:12 t 6:54 PM when the hot water in e result was harm to Resident #19.  The report stated Nurse Aide (NA) vel. The nurse aide realized the rse aide admitted to not looking at burns to lower legs, feet, thighs, pend the nurse aide, take all tubs otified, as well as, the ombudsman,  was also received by the state resident with severe burns timely, addition to the nurse aide and a  cy. This incident stated MS #76 I not meet regulatory guidelines, to meet regulatory compliance, r temperature and chose to keep it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 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 s	ocial service supervisor.		
	A five day follow up to the immedia	te 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 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 assi 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 bel disturbances, unspecified psychosis not due to a substance or known physiological condition, per vascular disease (PVD), alcohol dependence in remission, Fabry's disease, and high blood press Brief Interview for Mental Status (BIMS) was able to be obtained as the only verbal response was The resident was incontinent of bowel and bladder and required total care. The state of [NAME] vaserved as health care surrogate for this resident.			
	d) Timeline			
	A timeline provided by the facility reby Nurse Aide (NA) #99.	evealed Resident #19 was taken to the	tub room on 01/04/24 at 7:12 PM	
	The following information is a review of the videotape of the hallway activity conducted by the Soc (SW) and the Minimum Data Set (MDS) Coordinator. This video was on 01/04/24 and reviewed or			
	7:12 PM Resident #19 was taken to	the tub room by Nurse Aide (NA) #99		
	(continued on next page)			
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			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
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For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	7:16 PM NA #99 out in the hall time 7:17 PM NA #99 out of the tub room 7:20 PM NA #99 to Nurses Station room. 7:21 PM NA #41 leaves the tub room 7:23 PM NA #41 in NS and leaves 7:26 PM NA #41 in the tub room the 7:29 PM NA #99 out in the hall to the 7:33 PM NA #99 to NS and appear down the hall and they both go to the 7:35 PM NA #59 to NS. 7:36 PM NA #59 and RN #100 to the 7:36 PM NA #59 and RN #100 to the 7:37 PM RN #100 returns to NS 7:52 PM NA #99 to NS and back to 7:54 PM NA #99 to NS and back to 8:00 PM RN #100 to tub room 8:02 PM RN #100 to tub room 8:02 PM RN #100 to NS 8:04 PM NA #63 arrives from Unit Aside PM NA #61 leaves NS and go 8:15 PM NA #59 to NS and back to 8:25 PM NA #59 to NS and back to 8:25 PM NA #63 leaves Resident #68	es two (2) and back to the tub room.  m-went to Resident #19's room and ref (NS) then part way up hall got NA #41  om and goes to the NS back to the tub the NS (nurses station) at 7:24 PM.  en to NS at 7:27 PM.  the linen cart and returns to the tub room to to be returning to the tub room. NA #  the tub room  of tub room  A1 to assist.  the tub room.  ck to his room.  of Resident #19's room	and together they went to the tub room and back to NS.  m.  199 gets NA #59 who is coming eturns to Resident #19's room.
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OF SUPPLIED		STREET ADDRESS CITY STATE 71	D CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive	
Hopemont Hospital		Terra Alta, WV 26764	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0689	8:33 PM NA #63 leaves Resident #	19's room and returns with more linen	S.
Level of Harm - Immediate	8:38 PM NA #63 to NS and then to	tub room	
jeopardy to resident health or safety	8:40 PM NA #59 to the tub room ar	nd then NS	
Residents Affected - Many	8:41 PM NA #63 and #59 return to	Resident #19's room.	
	8:42 PM NA #59 goes down B1 ha	Il then returns to Resident #19's room.	
	8:43 PM NHA (nursing home admit then to Resident #19's room.	nistrator) on the unit and immediately g	oes to the tub room then NS and
	A review of a nursing progress note by RN #100 revealed the resident was transferred on 01/04/24 at PM to the local hospital. Resident #19 was documented to have blistering and peeling skin to bilateral 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		
	e) Investigation Statements	,	
	-HSW (health service worker) #99		
	Statement dated 01/04/24 as follow	ie.	
	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 follow	<b>/</b> S:	
	(continued on next page)		

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NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	asked me to lower the water temp. looked at the temp gauge and it waturned the temp down and ran cold task I was doing. Then when I walk happened. 1/4/24 9:01 pm I knew told me it was normal and how to fight of the second of t	er to B. As I was walking down the unit I walked in and put my hand in the walk is 134. The water was past his knees be water in the bath. It cooled down and the bath walk is 140 but I didn't walk is 150 but I didn't walk	ter and said that's hot. the [sic] but not running. I immediately went out of the bath back to my diblisters and recalled what report it because the other staff states and season and states are season as the season and season as the season
	I arrived at Hopemont once being r (last name) RN #100 was at the nu went to his room and CNA staff addiffrst name) #19 was burned and sh while in the tub and left the bathroot Resident #19 and stated he is in of nurse never came to his room. My addressing this issue were implement thoroughly. I went to the nurses stated pain management now. I as the doctor. I told her something newsent out and that it was almost 30 mesident and his care needs.  I helped interview her with the socials a long term RN and having works.	nade aware of this issue of the burn. It is reses station. She said to me (Resident vised they repeatedly told (RN first name eneeded to look at him. They said she on. They got him out of the tub and too evious discomfort and pain that needs to involvement and goal was to see that a sented to identify, correct, process, and stion after watching the resident writhing ked if she had been to his room. She seeds to be done now. Further I learned the minutes before RN #100 even called 9 and worker. She excused her action on the seed here before she was well aware of ead and that emergency care is immediated.	first name) #19 is in his room. I ne) RN #100 that resident (resident only momentarily observed him k him to his room. I observed to be addressed. They stated the appropriate steps regarding investigate the matter fully and g in pain. I advised RN #100 he aid no and asked if she should call that the doctor ordered the resident 11. She in no way assessed the raining and orientation. I explained the process, care responsibility,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	D CODE
		150 Hopemont Drive	PCODE
Hopemont Hospital	Hopemont Hospital 150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	This nurse was at nurses desk whe (Resident #19) feet normally peel. later and asked nurse to come and about 1 inch red and feet were red, numbers to try and contact on call. immediate. Got on call number from On call supposed to re-contact. Co large and redness moving up his let Contacted back by phone and seven 911 and gave report. Contacted MI med. Paper work put together and date nor times when this statement resident assessments completed.  A review of of nursing progress not PM) found the following:  The resident left the facility on [DAT blistering and peeling skin to bilate. Registered Nurse (RN) #100 on 01 of the facility was obtained by the F #99) first began asking RN #100 fowater on 01/04/24 at 7:36 PM.  f) A review of the water temperature. Water Temperature Leaving Mixing water to resident care areas as followed to resident care areas as followed at the resident care areas as followed at	en first CNA came out to desk from sho Told CNA I would check on it. Other CN assess residents feet. This nurse went, blistering and starting to peel. Attempted to There was no answer. Attempted to me another staff and (unable to determinate the MD for order to send out after stags. Delay in call back from on call. MD eral minutes later contacted by ADON. Deach as ADON arrived and went to stags arrived after giving pain med. Signt was to when it was written and no time the state of the most of	wer room and asked if resident's NA approached several minutes it to assess feet. Lower part of legs ited to contact A! to get phone essage on call but reply not the this word). Informed of situation. Second assessment with blisters gave permission to send out. Called the resident to get order for pain ned by RN #100. There was no the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated 01/04/24 at 20:27 (8:37). The dated of the resident as having the dated of the resident as having the dated of the resident as having the resident as having the dated of the resident as having the resident as havi
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
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 DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0689  Level of Harm - Immediate jeopardy to resident health or safety	03/07/23 124 degrees (F), 03/08/23 03/16/23 120 degrees (F), 03/20/23	3 120 degrees (F), 03/03/23 124 degree 3 126 degrees (F), 03/09/23 126 degree 3 130 degrees (F), 03/21/23 130 degree 124 degrees (F), 03/28/23 128 degree	es (F), 03/10/23 130 degrees (F), es (F), 03/22/23 119 degrees (F),
Residents Affected - Many	04/03/23 120 degrees (F), 04/04/23 04/07/23 121 degrees (F), 04/10/23 04/13/23 121 degrees (F), 04/14/23	3 126 degrees (F), 04/05/23 124 degrees (F), 04/11/23 124 degrees (F), 04/11/23 124 degrees (F), 04/17/23 125 degrees (F), 04/21/21 122 degrees (F), 04/21/21 4 degrees (F), 04/21/21	es (F), 04/12/23 123 degrees (F), es (F), 04/18/23 120 degrees (F),
		3 128 degrees (F), 04/26/23 115 degree	es (F), 04/28/23 120 degrees (F)
	05/05/23 118 degrees (F), 05/10/23 05/16/23 126 degrees (F), 05/17/23 05/22/23 122 degrees (F), 05/23/23	3 124 degrees (F), 05/03/23 122 degrees (F), 05/01/23 124 degrees (F), 05/11/23 124 degrees (F), 05/18/23 120 degrees (F), 05/24/23 116 degrees (F), 05/31/23 124 degrees (F),	es (F), 05/15/23 120 degrees (F), es (F), 05/19/23 118 degrees (F), es (F), 05/26/23 130 degrees (F),
	06/07/23 120 degrees (F), 06/08/23 06/13/23 126 degrees (F), 06/14/23 06/19/23 121 degrees (F), 06/20/23	3 112 degrees (F), 06/05/23 120 degrees (F), 06/09/23 130 degrees (F), 06/09/23 130 degrees 122 degrees (F), 06/15/23 124 degrees (F), 06/21/23 120 degrees (F), 06/27/23 122 degrees 124 degrees (F)	es (F), 06/12/23 118 degrees (F), es (F), 06/16/23 118 degrees (F), es (F), 06/22/23 122 degrees (F),
	07/11/23 116 degrees (F), 07/14/23 07/19/23 124 degrees (F), 07/20/23 07/27/23 118 degrees (F), 07/28/23	3 120 degrees (F), 07/07/23 120 degree 3 120 degrees (F), 07/17/23 122 degree 3 114 degrees (F), 07/21/23 128 degree 3 122 degrees (F), 07/31/23 120 degree	es (F), 07/18/23 132 degrees (F), es (F),07/26/23 120 degrees (F),
	08/07/23 120 degrees (F), 08/08/23 08/11/23 130 degrees (F), 08/14/23 08/18/23 136 degrees (F), 08/21/23	3 118 degrees (F), 08/03/23 120 degrees (F), 08/09/23 118 degrees (F), 08/15/23 129 degrees (F), 08/15/23 129 degrees (F), 08/22/23 124 degrees (F), 08/28/23 130 degrees (F), 08/28/23 130 degrees (F), 08/28/23 130 degrees	es (F), 08/10/23 122 degrees (F), es (F), 08/16/23 118 degrees (F), es (F), 08/23/23 133 degrees (F),

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			No. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICE	CIENCIES full regulatory or LSC identifying informat	ion)
F 0689	September 2023		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	09/08/23 130 degrees (F), 09/11/23	3 128 degrees (F), 09/06/23 130 degre 3 126 degrees (F), 09/12/23 124 degre 3 126 degrees (F), 09/20/23 124 degre	es (F), 09/13/23 121 degrees (F),
	10/09/23 140 degrees (F), 10/10/23 degrees (F), 10/17/23 130 degrees	3 130 degrees (F), 10/04/23 132 degre 3 138 degrees (F), 10/11/23 10/13/23 1 4 (F), 10/18/23 124 degrees (F), 10/19/2 5 (F), 10/25/23 128 degrees (F), 10/26/2 6 (F), 10/31/23 132 degrees (F)	130 degrees (F), 10/16/23 120 23 124 degrees (F),10/20/23 128
	November 2023		
		3 132 degrees (F), 11/03/23 141 degre 3 130 degrees (F), 11/09/23 134 degre	
	December 2023		
	12/07/23 128 degrees (F), 12/08/23 12/13/23 140 degrees (F), 12/14/23	3 130 degrees (F), 12/05/23 132 degre 3 132 degrees (F), 12/11/23 130 degre 3 140 degrees (F), 12/15/23 138 degre 3 140 degrees (F), 12/26/23 128 degre	es (F), 12/12/23 126 degrees (F), es (F), 12/20/23 130 degrees (F),
	January 2023		
	There were no temperatures avaia recorded after the incident.	lble prior to 01/04/24 when a temperate	ure of 140 degrees (F) was
		peratures continued to be above 110 d res logs revealed temperateurs were to	
	There were no temperatures recorded on weekends and holidays.		
	corrective action or adjustments to recorded above 110 degrees Fahre Approximately 121 days had tempe logged by the Maintenance Depart	PM, revealed no evidence was provide the resident hot water system when we enheit (F) monthly from January 2023 to eratures logged above 110 degrees Fa ment Staff for resident corridors A1, B1 w on 01/09/24 at 2:20 PM. with the As	ater temperatures were routinely hrough December 2023. hrenheit. These temperatures were I, and resident areas ([NAME]) and
	(continued on next page)		
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NAME OF PROVIDER OR SUPPLI	ED.	STREET ADDRESS, CITY, STATE, ZI	D CODE
	ER	150 Hopemont Drive	PCODE
Hopemont Hospital		Terra Alta, WV 26764	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689	Nurse Educator (NE) #78		
Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	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 be shut down in the resident care a	e a statement to the surveyor indicating areas on 01/07/24 at 6:54 PM.	he ordered access to all hot water
		ormance Improvement Committee (QA is the current situation of water temps for	
	Documentation revealed that water temps were being checked every hour since 01/05/24 at the four (4) mair 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 01/08/2 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 wa 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.		
		education was provided to staff reiteration tenance work orders if issues are susp	
	#97 revealed the perceived issue v serving resident corridors A1 and E have failed in the close position and system was drained and refilled with	proximately 11:36 AM., with the Director with the hot water system was a faulty the street of the Nursing Building. The issue will do was discovered mid-morning on Fridath 55-degree city water. An isolation variater temperatures were not supposed to	hermostat on the hot water tank ith the thermostat was believed to ay, January 5th. The hot water Ive was added on Monday, January
	Dining Areas. The temperature of h (F). Hot water to the other resident the basement and handles remove	imately 12:14 PM. revealed the only honor water at a hand sink in the Dining at areas such as Corridor A1, B1, and cod form faucets and fixtures to prevent radjustments were made to the system.	rea was noted as 109.1 degrees viridor [NAME] 1 was isolated off in residents from accidentally turning
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NAME OF PROVIDER OR CURRU		CTREET ADDRESS CITY STATE 7	D. CODE
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	PCODE
Hopemont Hospital		Terra Alta, WV 26764	
For information on the nursing home's	s plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	Interview on 01/09/24 at approxima issue with a thermostat on a hot wa ball valve was also replaced as a seleaving this area to the resident are temperatures was maintained in eatemperatures above 110 degrees (I was not previously aware of what the phone interview on 01/10/24 at apphad been the Maintenance Supervitemperatures of the hot water systes supposed to be maintained at 110 on the floors. He said nursing would he did not report the daily/monthly to the floors. The said nursing would he did not report the daily/monthly to the Plant Operations, Maintenanges.  This policy outlined the testing and for the Plant Operations, Maintenang Maintenance and Casualty Prevent hospital wide monthly by members Safety Officer, who will then assign that all boiler room equipment gauge exceed 110 degrees Fahrenheit with In a conversation between the local mixing value was defective and woon on mixing valves available locally a	Intely 1:03 PM., with Building Maintenar after tank in the basement (Potato Roor uspected back-feed elimination. A gauseas was also replaced. Interview noted the front of the provided of the mechanical room. Interview noted the provided of the provided of the provided of the water temperatures were supposed or oximately 9:43 AM, with the Maintenasor for approximately 5 years. The integral as noted on the gauges and was avoided the provided of the tried to a diet him know if the temperatures see temperature logs to any committee or a second of the provided of the provi	nce Mechanic #95 revealed that an in) was discovered and replaced. A ge for the mixing valve for the water that a daily log of the water that he was not aware that brided what the gauges read and to be maintained at.  ance Supervisor #76 noted that he erview revealed he recorded the ware that the temperatures were keep temperatures warm enough med too cold. Interview noted that had not been asked for them.  Maintenance and Casualty date of approval on the signature  and documentation requirements ation from the Preventative urveillance, which is conducted ction reports are to be given to the department. This policy outlines and that patient hot water is not to ance Department immediately.  5 PM, the plumber stated the cating the mixing valve. There were mber also suggested that filters be

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NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		
Evel of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	Ensure that nurses and nurse aides that maximizes each resident's well 30153  Based on a review of the orientatio and nurse aides were able to demoneds. Registered Nurse #100 (RN burns. A nurse aide (NA) failed to exposed the resident to water at 13 Resident identifier: #19. Staff identic created an immediate jeopardy situle ended on 01/22/24 when all staff of 110 degrees (F) were recorded from that down on 01/07/24 at 6:54 PM. census: 44.  Findings included:  a) Facility Reportable Incident (FRI A facility reported incident was receput Resident #19 into a whirlpool to was too warm. She had another aid water temperature and this resulted left hand. The facility reported the isservice and check for malfunction, department, and the nurse aide regundance. This incident stated the regundance action taken was a shutdown of the bathtubs.  A third facility reported incident dathad been monitoring water temperature report revealed MS #76 said he was warmer per staff request.	in records, and staff interviews, the facionstrate competency skills and techniquely failed to render aid timely to Resident ensure one (1) of six (6) resident's safe to degrees Fahrenheit (F). This caused fiers: Registered Nurse (RN) #100, Nullation that began on 01/04/24 when the completed competencies on safe bathing manal and the potential to affect all residuals. This had the potential to affect all residued at the state agency on 01/05/24. The state agency on 01/05/24 alb. She filled the tub to the knee level. The turns aid in Resident #19 receiving severe burns mediate action taken was to suspended all protective services were notified,	lity failed to ensure licensed staff uses necessary to care for resident t #19 who sustained third degree ty during a bath. The nurse aide d third degree burns to the resident. rse Aide #99. This failed practice resident was place in the bath and g. Water temperatures more than access to resident care areas was dents residing in the facility. Facility  The report stated Nurse Aide #99 The nurse aide realized the water de admitted to not looking at the ns to lower legs, feet, thighs, and d the nurse aide, take all tubs out of the ombudsman, the local sheriff's  I was also received by the state or resident with severe burns timely. Addition to the nurse aide and a  accy. This incident stated MS #76 not meet regulatory guidelines. MS meet regulatory compliance. The operature and chose to keep it

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICE	CIENCIES full regulatory or LSC identifying informati	on)
F 0726  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	After reviewing camera and intervie assistant) that was giving (Residen Finally at 7:36 she went to shower room). No 1st aide administered be investigation over. (Registered Nur Did not administer treatment in a till (Registered Nurse #100) will be refered Excessive delay in treatment.  This report was completed by the search of the fill the f	ewing staff (Registered Nurse #100) was the #19) his bath to assess him. Another room and left at 7:37. At 8:44 she got of younit nurse until 9:05. Nurse (Register se #100) failed to assess (Resident #1 mely manner. I find this report to be submoved from schedule and her agency of social service supervisor.  The report for Certified Nurse Aide (NA) ewing NA #41 who was called to showe the was seen on camera leaving the shifted his to be substantiated. NA #41 of A #41 sent home until investigation is of A #41 sent home until investigation is called by the social service supervisor.  Tacility 10/12/2017. Medical diagnoses is not due to a substance or known physical pendence in remission, Fabry's disease IMS) was able to be obtained as the or revealed the resident was transferred of the resident's general condition was manual for feeding. The resident moved all extend to showel and bladder with impairment of the pendence in the resident was transferred to be revealed that Resident (#19) sent of bowel and bladder with impairment and the standard skin and blisters BLE. The note of the pendence in the standard skin and blisters BLE. The note of the pendence and put in 9:10pm. Morpus ident at 9:15PM by ambulance on a standard standard standard subject on a standard standard subject and put in 9:10pm. Morpus ident at 9:15PM by ambulance on a standard standard standard subject and put in 9:10pm. Morpus ident at 9:15PM by ambulance on a standard s	as asked by CNA (ceritfied nurse CNA asked nurse to assess him. order to send to ER (emergency ed Nurse #100) sent home until 9) when asked 3 times by CNAs. obstantiated for neglect of resident. Will be notified of decision.  #41 revealed:  #41 revealed:  #42 revealed:  #43 revealed:  #44 revealed:  #44 revealed:  #45 revealed:  #45 revealed:  #46 reroom and found the water too hot ower room and going to nurses id adjust water but failed to assist done. I find this report to be alle and her agency will be notified included dementia with behavioral resiological condition, peripheral resiological condition, peripheral resioned resource. No nearly verbal response was grunting.  #48 revealed:  #49 revealed:  #49 revealed:  #49 revealed:  #40 revealed:  #40 revealed:  #41 revealed:  #41 revealed:  #41 revealed:  #41 revealed:  #42 revealed:  #43 revealed:  #44 revealed:  #44 revealed:  #45 revealed:  #45 revealed:  #46 report to be notified to assist done. I find this report to be notif

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI  150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0726	7:12 PM Resident #19 was taken to the tub room by Nurse Aide (NA) #99.		
Level of Harm - Immediate	7:16 PM NA #99 out in the hall time	es two (2) and back to tub room.	
jeopardy to resident health or safety	7:17 PM NA #99 out of tub room-w	ent to Resident #19's room and returne	ed to tub room.
Residents Affected - Many	7:20 PM NA #99 to Nurses Station room.	(NS) then part way up hall got CNA #4	1 and together they went to tub
	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 appear down the hall and they both go to the	s to be returning to the tub room. CNA ne tub room together at 7:34.	#99 gets CNA #59 who is coming
	7:35 PM NA #59 to NS.		
	7:36 PM NA #59 and RN #100 to to	ub 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		
	8:22 PM NA #41 to NS and then ba		
	8:25 PM NA #63 leaves Resident # (continued on next page)	19's room, goes to linen cart and retur	ns to Resident #19's room.
	, ,		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		P CODE
olan to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
		on)
8:33 PM NA #63 leaves Resident #8:38 PM NA #63 to NS and then to 8:40 PM NA #59 to tub room and the 8:41 PM NA #63 and #59 return to 8:42 PM NA #59 goes down B1 hall 8:43 PM NHA (nursing home admir Resident #19's room.  8:44 PM ADON (assistant director of 8:45 PM ADON running from unit to 8:45 PM Building and Grounds Mar 8:47 PM NHA and BGM #76 in tub 8:49 PM BGM #76 checking water 8:50 PM CNA #63 to NS and return 8:56 PM NHA goes to the Nursing 8:57 PM Social Service Supervisor 8:57 PM CNA #63 running down has 9:00 PM CNA #63 returning with su 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) #10 9:06 PM RN #100 returns to NS	19's room and returns with more linens tub room nen NS Resident #19's room.  I then returns to Resident #19's room. nistrator) on unit and immediately goes of nursing) was on the unit and immediately goes to the supplies. nager (BGM) #76 on unit and goes to the room in hall us to Resident #19's room. Station.  (SSS) #70-Advocate arrives on the unit and goes to Resident #19's room.	to tub room then NS and then to ately went to Resident #19's room.
	IDENTIFICATION NUMBER: 51E148  Iden to correct this deficiency, please configurations of DEFIC (Each deficiency must be preceded by: 8:28 PM NA #63 leaves Resident #8:33 PM NA #63 leaves Resident #8:38 PM NA #63 to NS and then to 8:40 PM NA #59 to tub room and the 8:41 PM NA #63 and #59 return to 8:42 PM NA #59 goes down B1 hall 8:43 PM NHA (nursing home admir Resident #19's room.  8:44 PM ADON (assistant director of 8:45 PM ADON running from unit to 8:45 PM Building and Grounds Mar 8:47 PM NHA and BGM #76 in tub 8:49 PM BGM #76 checking water 8:50 PM CNA #63 to NS and return 8:56 PM NHA goes to the Nursing 3:8:57 PM Social Service Supervisor 8:57 PM CNA #63 running down has 9:00 PM CNA #63 returning with superior process of the 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) #10 9:06 PM RN #100 returns to NS 9:17 PM EMS leaves unit with Resident #10 PM EMS leaves unit with PM EMS leaves unit	IDENTIFICATION NUMBER: 51E148  A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764  Jan to correct this deficiency, please contact the nursing home or the state survey.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati  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 Resident #19's room. 8:44 PM ADON (assistant director of nursing) was on the unit and immediately goes Resident #19's room. 8:45 PM Building and Grounds Manager (BGM) #76 on unit and goes to to the state of th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF DROVIDED OD SUDDIU	NAME OF PROVIDED OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE	
	NAME OF PROVIDER OR SUPPLIER		PCODE	
Hopemont Hospital		150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0726	9:18 PM NHA and ADON on unit at NS			
Level of Harm - Immediate jeopardy to resident health or	9:19 PM NHA and ADON along wit	th NA #99 walking off unit		
safety	9:21 PM RN #100 pushes med car	t into hall		
Residents Affected - Many	1:20 AM RN #100 clocked out and	was escorted out of building by ADON		
	c) Assistant Director of Nursing (AI	DON)		
	In a statement by the Assistant Director of Nursing (ADON) stated (first name of RN #100) was called to bathroom for reported blisters of Resident #19 more than once. Eventually RN #100 went to observe, the 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 nurse) until 8:25 pm when she contacted the RN on call. Between 8pm and 8:25 pm she did get the doorder to send out. 8:26 pm doctors order to send out written. EMS records show she did not call them uses 154 pm.		y RN #100 went to observe, then d or pain management. RN #100 n call nurse, 911, EMS, other unit ad 8:25 pm she did get the doctor's	
	d) The Nursing Home Administrator's (NHA) statement dated 01/09/24 at 10:04 AM			
	to the resident floor. RN #100 was room. NHA said he went to Reside that Resident #19 was burned and while in the tub and left the bathroc observed Resident #19 and stated aides stated the nurse never came appropriate steps regarding address investigate the matter fully and thou resident writhing in pain. He advise been to his room. She said no and needed done now. Further he said	ility once he was made aware of this is: at the nurse's station. She said to me (nt #19's room and nurse aide staff advishe needed to look at him. They said som. They got him out of the tub and too he was in obvious discomfort and pain to his room. The NHA said his involversing this issue were implemented to id roughly. NHA said he went to the nurse ad RN #100 that he needed pain managasked if she should call the doctor. NH he learned the doctor ordered the resid sed before RN #100 called 911. NHA s	Resident first name) #19 was in his sed they repeatedly told RN #100 she only momentarily observed him k him to his room. NHA said he that needed addressed. The nursement and goal was to see that entify, correct, process, and es' station after watching the gement now. He asked if she had lA said he told her something dent sent out and that after	
	long-term RN and having worked h	er action on training and orientation. Ne tere before she was well aware of the p ed and that emergency care was imme	rocess, care responsibility,	
		pinion her actions clearly were a delay tion was completed; she was removed		
		of employee records for skills compete vidence was found of a skills competer		
	(continued on next page)			

RY STATEMENT OF DEFICITION of DEFICITION of DEFICITION of DEFICITION of Devidence was trations.  The Aide #99  0/24 at 10:24 AM a review of the ence was found of a skills contained to the contained of the ence was found of a skills contained to the ence was found of a skill of the ence was found of a skill of the ence was found of the ence with a set of Legend (How Met) under the ion, Verbalized Understanding as found on the New Staff Coion, Tour of Department and	full regulatory or LSC identifying information and as provided regarding skills demonstrated of employee records for skills compete competency being completed during or a start date of 11/13/23 and a completion r Section F. Other (Specify: Return Dering.  Drientation Competency included majord Facility, HIPPA Officer, Safety, Social, and Departmental Expectations/Tasles	agency.  management, and 67% on tion or evaluation of returned  ncies was conducted for HSW #99. entation dated 11/13/23. The New on date of 11/14/23 found in the monstration) handwritten  r topics of Initial Employee al Services, Ethics and Compliance,
RY STATEMENT OF DEFICI ficiency must be preceded by f 0 scored on a scenario-base e evaluation. No evidence was trations. e Aide #99 0/24 at 10:24 AM a review of ence was found of a skills continued in the service of	Terra Alta, WV 26764  tact the nursing home or the state survey and the state survey are stated to the nursing home or the state survey are stated to the state survey are stated to the	management, and 67% on tion or evaluation of returned  ncies was conducted for HSW #99. entation dated 11/13/23. The New on date of 11/14/23 found in the monstration) handwritten  r topics of Initial Employee at Services, Ethics and Compliance,
RY STATEMENT OF DEFICI ficiency must be preceded by f 0 scored on a scenario-base e evaluation. No evidence was trations. e Aide #99 0/24 at 10:24 AM a review of ence was found of a skills continued in the service of	ciencies full regulatory or LSC identifying information and as provided regarding skills demonstrated of employee records for skills compete competency being completed during or a start date of 11/13/23 and a completion of the competency in Section F. Other (Specify: Return Dering.  Orientation Competency included major of Facility, HIPPA Officer, Safety, Social, and Departmental Expectations/Tasl	management, and 67% on tion or evaluation of returned  ncies was conducted for HSW #99. entation dated 11/13/23. The New on date of 11/14/23 found in the monstration) handwritten  r topics of Initial Employee at Services, Ethics and Compliance,
ficiency must be preceded by formal process.  O scored on a scenario-base evaluation. No evidence was trations.  E Aide #99  O/24 at 10:24 AM a review of the ence was found of a skills colored as found of the ence with a sed Legend (How Met) under ion, Verbalized Understanding as found on the New Staff Coion, Tour of Department and Assurance, Infection Control	full regulatory or LSC identifying information and as provided regarding skills demonstrated of employee records for skills compete competency being completed during or a start date of 11/13/23 and a completion r Section F. Other (Specify: Return Dering.  Drientation Competency included majord Facility, HIPPA Officer, Safety, Social, and Departmental Expectations/Tasles	management, and 67% on tion or evaluation of returned  ncies was conducted for HSW #99. entation dated 11/13/23. The New on date of 11/14/23 found in the monstration) handwritten  r topics of Initial Employee al Services, Ethics and Compliance,
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ion, Tour of Department and Assurance, Infection Contro	d Facility, HIPPA Officer, Safety, Socia ol, and Departmental Expectations/Tasl	I Services, Ethics and Compliance,
ety section included the follo	owing:	
	ownig.	
ncy Codes		
ncy Preparedness		
Shelter in Place		
lanagement Plan		
Shooter Training		
Life Safety		
n Control		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDED OR CURRULED		STREET ADDRESS, CITY, STATE, ZI	D CODE
NAME OF PROVIDER OR SUPPLIER		150 Hopemont Drive	PCODE
Hopemont Hospital		Terra Alta, WV 26764	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 identif			on)
F 0726	Workplace Security		
Level of Harm - Immediate	Preventative Maintenance Require	ments	
jeopardy to resident health or safety	Maintenance Work Orders		
Residents Affected - Many	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 # concerned about the hot water in the sinks. In the email the nurse educator explains that the staff told not to use the hot water because it had been registering over 110 degrees (F). The nurse educated she was concerned that residents would use the sink and nursing could not monitor the sith her email the Nurse Educator said that Licensed Practical Nurse (LPN) #46 had asked about shurwater off and was told it could not be done.		
	NE #78 had a written statement da	ted 1/11/24.	
	NE #78 statement reflected she worked on 01/05/24 on B -1 from 6:30 PM - 10:30 PM. She worke Nurse Aide #63, #59, #87 on safe bathing, burns and maintenance orders. She also spoke with Rf #22 on the subject as well. An in-service was held on bathing, burns and safe temperatures. This i had a post test. On 01/07/24 10 staff members attended; on 01/08/24 13 attended on 01/09/24 one attended and on 01/10/24 one (1) attended.		s. She also spoke with RN #62, and safe temperatures. This in-service
	(continued on next page)		

			No. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Hopemont Hospital		150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0726  Level of Harm - Immediate jeopardy to resident health or safety	handouts that included a copy of th bath or shower, various bathing tec Burns, and a copy of the Maintenar	the Staff Development Educator which included Bathing and burns with of the chain of command, flow chart for reporting process, assisting with a tub techniques, CMS chart Time and Temperature Relationship to Serious enance Work Order. 11 staff attended on 01/07/24, 10 staff attended on 04 and 01/10/24 respectively and 8 attended on 01/11/24.		
Residents Affected - Many	h) Maintenance Director and Mainte	enance 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.			
	1			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZI	P.CODE	
Hopemont Hospital		150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0908	Keep all essential equipment worki	ng safely.		
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153 37324			
Residents Affected - Many	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 to the immediate action taken was a suspension of the registered nurse in addition to the nurse aide and 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 not meet regulatory guidelines. MS #76 failed to report the temperatures or attempt to make any characteristic 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 (ceritf assistant) that was giving (Resident #19) his bath to assess him. Another CNA asked nurse to as Finally at 7:36 she went to shower room and left at 7:37. At 8:44 she got order to send to ER (erroom). No 1st aide administered by unit nurse until 9:05. Nurse (Registered Nurse #100) sent he investigation over. (Registered Nurse #100) failed to assess (Resident #19) when asked 3 times Did not administer treatment in a timely manner. I find this report to be substantiated for neglect (Registered Nurse #100) will be removed from schedule and her agency will be notified of decision excessive delay in treatment.			
	(continued on next page)			

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID:

If continuation sheet Page 26 of 40

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF DROVIDED OD CURRU		CTREET ADDRESS CITY STATE 7	ID CODE	
NAME OF PROVIDER OR SUPPLII	ER	STREET ADDRESS, CITY, STATE, ZI	IP CODE	
Hopemont Hospital		150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0908	This report was completed by the social service supervisor.			
Level of Harm - Immediate jeopardy to resident health or	A five day follow up to the immedia	te report for Certified Nurse Aide (NA)	#41 revealed:	
safety				
Residents Affected - Many	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) #7	76		
	A phone interview on 01/10/24 at approximately 9:43 a.m., with MS #76 noted he had been the Supervisor for approximately 5 years. Interview revealed he recorded the temperatures of the hot system as noted on the gauges and seemed to be aware that the temperatures were supposed maintained at 110 degrees Fahrenheit. He also noted that he tried to keep temperatures warm of the floors as Nursing would let him know if the temperatures seemed too cold. Interview noted the report the daily/monthly temperature logs to any committee or had not been asked for them by a reporting committees, such as the Safety Committee or the Quality and Performance Improvement Committee.			
	d) Preventative Maintenance and C	Casualty Prevention Plan Notes		
	(continued on next page)			

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Facility ID: 51E148

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDED OF CURRUED		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Hopemont Hospital			. 6052	
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey :	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
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 va	live are as follows:	
	January 2023			
	01/09/23 120 degrees (F), 01/10/23 01/15/23 120 degrees 126 degrees	3 120 degrees (F), 01/05/23 118 degree 3 126 degrees (F), 01/11/23 122 degree 5 (F), 01/18/23 124 degrees (F), 01/19/2 5 (F), 01/25/23 122 degrees (F), 01/26 6 (F), 01/31/23 126 degrees (F),	es (F), 01/12/23 120 degrees (F), 23 122 degrees (F), 01/20/23 120	
	February 2023			
	02/08/23 130 degrees (F),02/13/23 02/16/23 126 degrees (F), 02/17/23	3 124 degrees (F), 02/06/23 126 degree 126 degrees (F), 02/14/23 124 degree 3 128 degrees (F), 02/21/23 124 degree 3 128 degrees (F), 02/27/23 120 degree	es (F), 02/15/23 128 degrees (F), es (F), 02/22/23 128 degrees (F),	
	March 2023			
	03/07/23 124 degrees (F), 03/08/23 03/16/23 120 degrees (F), 03/20/23	3 120 degrees (F), 03/03/23 124 degree 3 126 degrees (F), 03/09/23 126 degree 3 130 degrees (F), 03/21/23 130 degree 124 degrees (F), 03/28/23 128 degree	es (F), 03/10/23 130 degrees (F), es (F), 03/22/23 119 degrees (F),	
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital  STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive Terra Alta, WV 26764		P CODE		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0908	April 2023			
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	diate ealth or $04/03/23 \ 120 \ degrees (F), \ 04/04/23 \ 126 \ degrees (F), \ 04/05/23 \ 124 \ degrees (F), \ 04/06/23$ ealth or $04/07/23 \ 121 \ degrees (F), \ 04/10/23 \ 120 \ degrees (F), \ 04/11/23 \ 124 \ degrees (F), \ 04/12/23$ $04/13/23 \ 121 \ degrees (F), \ 04/14/23 \ 115 \ degrees (F), \ 04/17/23 \ 125 \ degrees (F), \ 04/18/23$ $04/19/23 \ 119 \ degrees (F), \ 04/20/23 \ 121 \ degrees (F), \ 04/21/21 \ 122 \ degrees (F),$			
	05/05/23 118 degrees (F), 05/10/23 05/16/23 126 degrees (F), 05/17/23 05/22/23 122 degrees (F), 05/23/23	3 124 degrees (F), 05/03/23 122 degre 3 116 degrees (F), 05/11/23 124 degre 3 130 degrees (F), 05/18/23 120 degre 3 120 degrees (F), 05/24/23 116 degre 3 120 degrees (F), 05/31/23 124 degre	es (F), 05/15/23 120 degrees (F), es (F), 05/19/23 118 degrees (F), es (F)< 05/26/23 130 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 06/07/23 120 degrees (F), 06/08/23 130 degrees (F), 06/09/23 130 degrees (F), 06/12/23 118 06/13/23 126 degrees (F), 06/14/23 122 degrees (F), 06/15/23 124 degrees (F), 06/16/23 118 06/19/23 121 degrees (F), 06/20/23 114 degrees (F), 06/21/23 120 degrees (F), 06/22/23 122 06/23/24 116 degrees (F), 06/26/23 131 degrees (F), 06/27/23 122 degrees (F), 06/28/23 124 06/29/23 120 degrees (F), 06/30/23 124 degrees (F)			
	July 2023			
	07/11/23 116 degrees (F), 07/14/23 07/19/23 124 degrees (F), 07/20/23	3 120 degrees (F), 07/07/23 120 degre 3 120 degrees (F), 07/17/23 122 degre 3 114 degrees (F), 07/21/23 128 degre 3 122 degrees (F), 07/31/23 120 degre	es (F), 07/18/23 132 degrees (F), es (F),07/26/23 120 degrees (F),	
	August 2023			
	08/07/23 120 degrees (F), 08/08/23 08/11/23 130 degrees (F), 08/14/23 08/18/23 136 degrees (F), 08/21/23	3 118 degrees (F), 08/03/23 120 degre 3 121 degrees (F), 08/09/23 118 degre 3 121 degrees (F), 08/15/23 129 degre 3 120 degrees (F), 08/22/23 124 degre 3 126 degrees (F), 08/28/23 130 degre	es (F), 08/10/23 122 degrees (F), es (F), 08/16/23 118 degrees (F), es (F), 08/23/23 133 degrees (F),	
	September 2023			
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital  STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive Terra Alta, WV 26764			P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)	
F 0908  Level of Harm - Immediate jeopardy to resident health or safety	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)			
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), 10/10/23 140 degrees (F), 10/10/23 138 degrees (F), 10/11/23 10/13/23 130 degrees (F), 10/16/2 degrees (F), 10/17/23 130 degrees (F), 10/18/23 124 degrees (F), 10/19/23 124 degrees (F), 10/24/23 132 degrees (F), 10/25/23 128 degrees (F), 10/26/23 130 degrees (F), 10/10/25/23 130 degrees (F), 10/25/23 130 degrees (F			
	November 2023  11/01/23 128 degrees (F), 11/02/23 132 degrees (F), 11/03/23 141 degrees (F), 11/07/23 128 degrees (F), 11/08/23 130 degrees (F), 11/09/23 134 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 12/07/23 128 degrees (F), 12/08/23 132 degrees (F), 12/11/23 130 degrees (F), 12/12/23 12/13/23 140 degrees (F), 12/14/23 140 degrees (F), 12/15/23 138 degrees (F), 12/20/23 12/21/23 126 degrees (F), 12/22/23 140 degrees (F), 12/26/23 128 degrees (F), 12/28/23 12/29/23 130 degrees (F)			
	January 2024			
		peratures continued to be above 110 de res logs revealed temperateurs were ta		
	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	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 in that specific area and make corrections. You must document when notification was material transfer or the specific area and make corrections. You must document when notification was material transfer or the specific area and make corrections.				
(continued on next page)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED 02/09/2024	
	012110	B. Wing		
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Hopemont Hospital 150 Hopemont Drive Terra Alta, WV 26764				
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)	
F 0908	j) Nurse Educator (NE) #78	j) Nurse Educator (NE) #78		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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 administrate 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 completed each hour. Temperatures found to be greater than 110 degrees, were to be reported to the administrator, residents were to be prevented from using the identified outlet(S), and med adjustments made to the hot water system in order to bring temperatures below 110 Fahrenheir 01/08/24, due to residents no longer having access/exposure to hot water outlets, the QAPI teather monitoring of hot water temperatures to an as needed basis due to repairs actively being materials.			
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0908  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	discuss the current situation of wat were being checked every hour sin and the resident showers on the condition of the currently have no access to hot was mechanical issues with an isolation valve and gauge were discovered. The condition of the survey. The wast being ordered for repair during and no rinse shampoo and body with the condition of	ducation was provided to staff reiteratic tenance work orders if issues are susponding. The susponding the hot water system was a faulty to the Nursing Building. The issue with the hot water system was a faulty to the Nursing Building. The issue with divident waters discovered mid-morning on Fridath 55-degree city water. An isolation value hot water temperatures were not supported to the susponding that the only hot water temperature of the hot water as recording the other resident areas such as Corridon and the repairs and adjustments were resulted that the susponding with the susponding that the susponding that the susponding that the water that a daily log of the water that a daily log of the water that a daily log of the water that and only recorded what the gauges resulted that a daily log of the water that and only recorded what the gauges resulted that a daily log of the water that and only recorded what the gauges resulted that a daily log of the water that and only recorded what the gauges resulted that a daily log of the water that and only recorded what the gauges resulted that a daily log of the water that and only recorded what the gauges resulted that the subject to the subject that the subject tha	tion revealed that water temps on Resident corridors of A1 and B1 locumentation forwarded to 4. Repairs were initiated on the hot not care areas and residents or to the time of survey, potential a water system distribution mixing ixing valve gauge had been as being investigated further with dothat they would be using wipes and Plant Operations #97 hermostat on the hot water ected with the temperature of the and Plant Operations #97 hermostat on the hot water tank with the thermostat was believed to any, January 5th. The hot water live was added on Monday, January osed to be above 110 degrees.  The state being provided to the resident ed at a hand sink in the Dining area or A1, B1, and [NAME] 1 was est to prevent residents from made to the system.  The with a thermostat on a hot water valve was also replaced as a er leaving this area to the resident remperatures was maintained in aware that temperatures above ead and was not previously aware to the susues with the water 8th. Employee #14 noted that he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER (X2) PUPILER (S1E148    STREET ADDRESS, CITY, STATE, ZIP CODE   Sold hopemont Drive   Torra Alla, WY 26784   Torra Alla, WY 26784   Torra Alla, WY 26784   SUMMARY STATEMENT OF DEFICIENCIES   (Each deficiency must be preceded by full regulatory or LSC identifying information)  F 0908    Diffig 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 warm enough on the floors as Nursing would let him know if the temperatures server supposed to be maintenance and 110 degrees. He also noted that he fired to keep temperatures warm enough on the floors as Nursing would let him know if the temperatures server supposed to be maintenance and Causalty Prevention Plan  The Office of Health Facilities Policy (Policy OHF LS.0002) for Preventive Maintenance and Causualty Prevention Plan has been updated to include an effective date based upon the date of approval on the Preventiative Maintenance and Causualty Prevention Plan is monitored in the monitorial provided the prevention Plan has been updated to include an effective date based upon the date of approval or from the Preventiative Maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the head of the provided that the prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored in the maintenance and Causualty Prevention Plan is monitored into the Maintenance and Causualty Prevention Plan is monitore				NO. 0930-0391	
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)  p) Maintenance Supervisor (MS) #76  Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many  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		IDENTIFICATION NUMBER:	A. Building	COMPLETED	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  p) Maintenance Supervisor (MS) #76  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many  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 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			150 Hopemont Drive	IP CODE	
Each deficiency must be preceded by full regulatory or LSC identifying information)    Possible	For information on the nursing home's	plan to correct this deficiency, please con	Lact the nursing home or the state survey	agency.	
Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many  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	(X4) ID PREFIX TAG				
	F 0908  Level of Harm - Immediate jeopardy to resident health or safety	p) Maintenance Supervisor (MS) #  During a phone interview on 01/10, been the Maintenance Supervisor temperatures of the hot water systetemperatures were supposed to be temperatures warm enough on the he did not report the daily/monthly  q) Preventive Maintenance and Ca  The Office of Health Facilities Polic Prevention Plan has been updated signature page. This policy outlines documentation requirements for the from the Preventative Maintenance which is conducted hospital wide mare to be given to the Safety Office This policy outlines that all boiler rehot water is not to exceed 110 deg	full regulatory or LSC identifying informate 76  724 at 9:43 AM, the Maintenance Super for approximately five (5) years.MS #76 are as noted on the gauges and seemed an anintained at 110 degrees. He also noted floors as Nursing would let him know it temperature logs to any committee or ualty Prevention Plan  8y (Policy OHF.LS.0002) for Preventive to include an effective date based upon the testing and preventative maintenates are plant Operations, Maintenance, and and Casualty Prevention Plan is mon nonthly by members of the Safety Common, who will then assign corrective actions of the quipment gauges are to be visual	rvisor (MA) #76 noted that he had 6 noted that he recorded the ed to be aware that the loted that he tried to keep of the temperatures s#76 noted that had not been asked for them.  Maintenance and Casualty on the date of approval on the lance procedures and Engineering Staff. Documentation itored through safety surveillance, limittee. These inspection reports in from the appropriate department. Ily monitored daily and that patient	

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			NO. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLIE Hopemont Hospital	ER	STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE	
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		MMARY STATEMENT OF DEFICIENCIES  h 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	Make sure that the nursing home a public.  **NOTE- TERMS IN BRACKETS Hased on observation, record revie equipment in safe operating condition degrees Fahrenheit (F) can lead to degrees (F) water. Resident #19 subilateral buttocks, and scrotum. The equipment knew the hot water had an immediate jeopardy situation the potential to affect all facility resident.  Findings included:  a) Facility Reported Incident  A facility reported incident was receput Resident #19 into a whirlpool to was too warm. She had another aid water temperature and this resulted hand. The facility reported the imm service and check for malfunction. department, and the nurse aide regulatery. This incident stated the regulation aide and a shutdown of the bathtub. A third facility reported incident dat Maintenance Supervisor (MS) #76 not meet regulatory guidelines. MS meet regulatory compliance. The retemperature and chose to keep it work. The five (5) day follow up report ob.  After reviewing camera and interview assistant) that was giving (Residen Finally at 7:36 she went to shower room). No 1st aide administered by investigation over. (Registered Nur Did not administer treatment in a time.	rea is safe, easy to use, clean and con IAVE BEEN EDITED TO PROTECT Cow, and staff interview the licensee faile on. According to CMS guidelines expothird degree burns in 15 seconds. Resustained second degree burns to the lest staff responsible for monitoring water measured more than 110 degrees (F) at began on 01/03/23 and ended on 01 ts. Resident identifier: #19. Facility centers to adjust the water. The nurse aid in Resident #19 receiving severe burnediate action taken was to suspend the Adult protective services were notified, gistry.  Idated 01/04/24 related to Resident #19 gistered nurse (RN #100) did not assess taken was a suspension of the registers.  Let 01/05/24 was sent to the state agenthad been monitoring water temperatures of the protective services was a w	on of the control of	
	(continued on next page)			

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	51E148	A. Building B. Wing	02/09/2024	
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SUPPLIER		P CODE	
Hopemont Hospital		150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0921	This report was completed by the social service supervisor.			
Level of Harm - Immediate jeopardy to resident health or	A five day follow up to the immedia	te report for Certified Nurse Aide (NA)	#41 revealed:	
safety  Residents Affected - Many	After reviewing camera and interviewing NA #41 who was called to shower room and found the water and adjusted water temperature. She was seen on camera leaving the shower room and going to nurs station but camera has no sound. I find this to be substantiated. NA #41 did adjust water but failed to a 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 no 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 (F), 01/18/23 124 degrees (F), 01/19/23 122 degrees (F), 01/20/23 12 degrees (F), 01/24/23 126 degrees (F), 01/25/23 122 degrees (F), 01/26/23 126 degrees (F), 01/27/23 12 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), 01/30/23 126 degrees (F), 01/30/23 126 degrees (F), 01/31/23 126 degrees (F), 01/30/23 126 degrees (			
	February 2023			
	02/02/23 124 degrees (F), 02/03/23 124 degrees (F), 02/06/23 126 degrees (F), 02/07/23 124 02/08/23 130 degrees (F),02/13/23 126 degrees (F), 02/14/23 124 degrees (F), 02/15/23 128 02/16/23 126 degrees (F), 02/17/23 128 degrees (F), 02/21/23 124 degrees (F), 02/22/23 128 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 12 03/07/23 124 degrees (F), 03/08/23 126 degrees (F), 03/09/23 126 degrees (F), 03/10/23 12 03/16/23 120 degrees (F), 03/20/23 130 degrees (F), 03/21/23 130 degrees (F), 03/22/23 1 03/23/23 124 degrees (F) 03/27/23 124 degrees (F), 03/28/23 128 degrees (F)			
	April 2023			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIE Hopemont Hospital	ĒR	STREET ADDRESS, CITY, STATE, ZI 150 Hopemont Drive Terra Alta, WV 26764	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0921  Level of Harm - Immediate jeopardy to resident health or safety	04/07/23 121 degrees (F), 04/10/23 04/13/23 121 degrees (F), 04/14/23	3 126 degrees (F), 04/05/23 124 degrees (F), 04/11/23 124 degrees (F), 04/11/23 125 degrees (F), 04/21/21 122 degrees (F)	es (F), 04/12/23 123 degrees (F), es (F), 04/18/23 120 degrees (F),
Residents Affected - Many	04/24/23 130 degrees (F), 04/25/23 May 2023	3 128 degrees (F), 04/26/23 115 degree	es (F), 04/28/23 120 degrees (F)
	05/01/23 120 degrees (F), 05/02/23 05/05/23 118 degrees (F), 05/10/23 05/16/23 126 degrees (F), 05/17/23 05/22/23 122 degrees (F), 05/23/23	3 124 degrees (F), 05/03/23 122 degrees (F), 05/11/23 124 degrees (F), 05/18/23 120 degrees (F), 05/24/23 116 degrees (F), 05/31/23 124 degrees (F),	es (F), 05/15/23 120 degrees (F), es (F), 05/19/23 118 degrees (F), es (F), 05/26/23 130 degrees (F),
	June 2023		
	06/01/23 120 degrees (F), 06/02/23 112 degrees (F), 06/05/23 120 degrees (F), 06/06, 06/07/23 120 degrees (F), 06/08/23 130 degrees (F), 06/09/23 130 degrees (F), 06/12, 06/13/23 126 degrees (F), 06/14/23 122 degrees (F), 06/15/23 124 degrees (F), 06/16, 06/19/23 121 degrees (F), 06/20/23 114 degrees (F), 06/21/23 120 degrees (F), 06/22, 06/23/24 116 degrees (F), 06/26/23 131 degrees (F), 06/27/23 122 degrees (F), 06/29/23 120 degrees (F), 06/30/23 124 degrees (F)		
	July 2023		
	07/11/23 116 degrees (F), 07/14/23 07/19/23 124 degrees (F), 07/20/23	3 120 degrees (F), 07/07/23 120 degree 3 120 degrees (F), 07/17/23 122 degree 3 114 degrees (F), 07/21/23 128 degree 3 122 degrees (F), 07/31/23 120 degree	es (F), 07/18/23 132 degrees (F), es (F),07/26/23 120 degrees (F),
	August 2023		
	08/07/23 120 degrees (F), 08/08/23 08/11/23 130 degrees (F), 08/14/23 08/18/23 136 degrees (F), 08/21/23	3 118 degrees (F), 08/03/23 120 degrees (F), 08/09/23 118 degrees (F), 08/15/23 129 degrees (F), 08/22/23 124 degrees (F), 08/28/23 130 degrees (F), 08/28/23 130 degrees (F), 08/28/23 130 degrees (F), 08/28/23 130 degrees	es (F), 08/10/23 122 degrees (F), es (F), 08/16/23 118 degrees (F), es (F), 08/23/23 133 degrees (F),
	September 2023		
	09/08/23 130 degrees (F), 09/11/23	3 128 degrees (F), 09/06/23 130 degrees (F), 09/12/23 124 degrees (F), 09/20/23 124 degrees (F), 09/20/23 124 degrees (F), 09/20/23 124 degrees (F), 09/20/23 124 degrees (F)	es (F), 09/13/23 121 degrees (F),
	(continued on next page)		

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			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive Terra Alta, WV 26764	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0921  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many			
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLII		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 con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	STATEMENT OF DEFICIENCIES  ncy 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	Record review, on 01/10/24 at 12:3 revealed that Safety Surveillance was correction to the proper department Plan these reports and corrective as Committee minutes. Record review Safety Surveillance was reported to 2023 through December 2023, as compared to 2023, as compared to 2023 through December 2023, as compared to 2023, as compared to 2023 through December 2023, as compared to 2023, as compared to 2023 through December 2023, as compared to 2023,	y full regulatory or LSC identifying information)  37 PM, of Preventative Maintenance and Casualty Prevention Plan was conducted hospital wide monthly by members of the Safety are given to the Safety Officer who will then assign the deficiency into for action. Per the Preventative Maintenance and Casualty Prevention action documents are also attached to the master copy of the Quality we revealed no documentation provided during the survey to show that to the Quality and Performance Improvement (QAPI) Committee from July outlined in the Preventative Maintenance and Casualty Prevention Plan.  In interview the assistant administrator and the administrator confirmed they imperatures being recorded by the maintenance employee, nor had they remaintenance was being done to the hot water equipment.  #19 was admitted to the facility 10/12/17. Medical diagnoses included inces, unspecified psychosis not due to a substance or known physiological rease (PVD), alcohol dependence in remission, Fabry's disease, and high of or Mental Status (BIMS) was able to be obtained as the only verbal to administrative staff dated 01/07/24 at 9:54 AM revealed NE #78 was still the sinks. In the email the nurse educator explains that the staff had been use it had been registering over 110 degrees (F). The nurse educator sidents would use the sink and nursing could not monitor the situation. In that Licensed Practical Nurse (LPN) #46 had asked about shutting the hot be done. Rercord review revealed the Nursing Home Administrator gave nut off at 6:54 PM on 01/07/24.		
	#66 stated she showed new emplo	esence of the Director of Nursing (DON yees how to operate the tub and then how this was documented, CNA #66 s don't have one now.	nad the new employee complete a	
	h) Quality Assurance and Performa	ance Improvement (QAPI)		
	(continued on next page)			

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 51E148

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive Terra Alta, WV 26764	
For information on the nursing home's pl	an to correct this deficiency, please conf	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many			

			No. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E148	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024	
NAME OF PROVIDER OR SUPPLIER  Hopemont Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Hopemont Drive Terra Alta, WV 26764		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0921  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Many	#97) revealed that the perceived is tank serving resident corridors A1 a believed to have failed in the close water system was drained and refil January 8th. Employee #97 also no degrees.  An observation on 01/09/24 at 12:1 areas was to the Dining Area. The	36 AM., with the Director of Facilities a sue with the hot water system was a fa and B1 of the Nursing Building. The iss position and was discovered mid-moralled with 55-degree city water. An isola ofted that hot water temperatures were 14 PM revealed that the only hot water temperature of the hot water recorded	aulty thermostat on the hot water sue with the thermostat was ning on Friday, January 5th. The hot tion valve was added on Monday, not supposed to be above 110 being provided to the resident 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 w 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 issue with a thermostat on a hot water tank in the basement (Potato Room) was discovered and rep ball valve was also replaced as a suspected back-feed elimination. A gauge for the mixing valve for 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 awatemperatures above 110 degrees needed to be reported and only recorded what the gauges read an 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			
	morning of Monday, January 8th. E temperatures needed to be reporte	work during the time of noted issues with the water system and had just returned of Monday, January 8th. BMM#14 noted that he was not aware that any issues wures needed to be reported to anyone.  phone interview on 01/10/24 at 9:43 AM, the Maintenance Supervisor (MS) #76 states.		
	the MS for approximately five (5) you system as noted on the gauges and maintained at 110 degrees. He also Nursing would let him know if the to	ears. MS #76 noted that he recorded the discerning of the temper of the that he tried to keep temperature of the tried to keep temperature of the tried to cold. Employ to any committee or had not been ask	ne temperatures of the hot water atures were supposed to be ures warm enough on the floors as ee #76 noted that he did not report	