STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Howland	4100 North River Road Howland, OH 44484

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to ensure Resident #36's advance directives were accurate. This affected one (Resident #36) out of two residents reviewed for advance directives. The facility census was 44. Findings include: Review of the medical record for Resident #36 revealed an admission date of [DATE] with diagnoses including dementia, spinal stenosis, and history of myocardial infarction. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had impaired cognition. Review of the care plan dated [DATE] revealed Resident #36's was a full code. Interventions included Resident #36 was a full code and cardiopulmonary resuscitation (CPR) was to be initiated and review advance directives periodically with resident and/or family. Review of the Do Not Resuscitate Comfort Care (DNRCC) form dated [DATE] and completed by Medical Director/Primary Care Physician (PCP) #619 revealed Resident #36 advance directive indicated he was a DNRCC-arrest. Review of the nursing note dated [DATE] and completed by Licensed Practical Nurse (LPN) #606 revealed Medical Director/PCP #619 was in the facility and signed the DNRCC form indicating Resident #36 was a DNRCC-arrest. Review of the [DATE] physicia'sn orders revealed Resident #36 had an order dated [DATE] that he was a full code. Interview on [DATE] at 11:53 A.M. with the Director of Nursing revealed when there was a medical emergency the expectation was that the nurse on duty checked the physician order in the electronic medical record for the resident's code status. She revealed the residents' code status orders in the electronic record were accurate; therefore, she did not give any guidance to the nurses to check the hard chart. She verified the current order in the electronic medical record dated [DATE] indicated Resident #36 was a full code, and the form in the chart dated [DATE] indicated he was a DNRCC-arrest. She also verified Resident #36's care plan revealed Resident #36 was a full code. She verified the advance directives were not accurate as the order in the electronic record and the care plan did not match the DNRCC form as Resident #36 was a DNRCC-arrest. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled Advanced Directives, dated [DATE], revealed the purpose of the policy was to ensure that the resident had the right to formulate an advance directive including the right to accept or refuse medical treatment. Advance directives were honored in accordance with state law and facility policy. The policy revealed the resident's wishes were communicated to the resident's direct care staff and physician by placing the advance directives documents in a prominent, assessable location in the medical record and discussing the wishes in the care plan meeting. The policy revealed the care plan for each resident would be consistent with his or her advance directive.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to ensure Resident #27's bowel elimination was monitored effectively. This affected one (Resident #27) out of one resident reviewed for constipation. The facility census was 44. Findings include: Review of the medical record for Resident #27 revealed an admission date of 10/28/22 with diagnoses including fractured right femur, gastroenteritis, colitis (inflammation of the colon), Alzheimer's disease, melena (black tarry stool), and diverticulosis (small, bulging pouches in the lining of the large intestine). Review of the care plan dated 11/04/22 revealed Resident #27 was at risk for constipation due to medication side effects, reduced mobility, weakness, colitis, and diverticulosis. Interventions included assessing and monitoring the resident's abdomen for distension, bowel sounds as ordered, assessing and monitoring bowel movements every shift, assessing and monitoring for medication side effects for constipation, encouraging exercise, initiating the facility bowel policy if indicated, medications as ordered, and monitoring daily fluid intake at meals. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had impaired cognition. She was dependent on staff assistance with toileting hygiene and transfers. She was always incontinent of bowel and bladder. She was on hospice services. Review of the May/June 2025 Physician Orders and May 2025 Medication Record Administration (MAR) revealed Resident #27 had the following orders dated 10/28/22: administer milk of magnesium (MOM) 400 milligram (mg) per milliliter (ml) give 30 ml by mouth as needed for constipation if greater than seven shifts with no bowel movement (BM), bisacodyl suppository 10 mg insert one suppository rectally as needed for constipation if greater that eight shifts with no BM, and Colace 100 mg give one capsule by mouth every 12 hours as needed for constipation. The MAR revealed on 05/20/25 at 5:52 A.M., MOM was administered to Resident #27 but was ineffective. The MAR indicated no bisacodyl suppositories and Colace were administered. Review of bowel elimination task bar from 05/07/25 to 06/06/25 revealed Resident #27 had a small BM on 05/14/25 and then there was no documentation she had any further BMs until 05/23/25 (nine days) at which time she had a large BM. The task bar revealed Resident #27 had a large BM on 05/27/25 and then there was no documentation she had a BM until 06/04/25 (eight days) at which time she had a small BM. The consistency of Resident #27's BM on 05/08/25 showed signs of constipation as it was hard. Review of the Visit Note Report dated 05/22/25 and completed by Hospice Registered Nurse (RN) #900 revealed the last known BM was 05/20/25. Review of June 2025 MAR revealed MOM was administered on 06/02/25 at 5:46 P.M. and was ineffective. The MAR indicated no bisacodyl suppositories and Colace were administered. Review of Visit Note Report dated 06/02/25 and completed by Hospice RN #900 revealed Resident #27 had bowel incontinence and last known BM was 06/01/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 10:24 A.M. with Director of Nursing (DON) and Assistant Director of Nursing (ADON)/Registered Nurse (RN) #583 revealed if a resident did not have a BM in three days, it showed up on the dashboard of the electronic medical record notifying the nurse. They revealed after three days of no BM, the nurse was to administer MOM and then if by the next day there was no results from the MOM, a bisacodyl suppository was to be administered unless otherwise indicated per the physician orders. They verified Resident #27 was dependent on staff for toileting assistance and was incontinent of bowel. They verified, per the task, bar Resident #27 had a small BM on 05/14/25 and then there was no documentation she had any further BMs until 05/23/25 (nine days) as at that time she had a large BM. They also verified, per the task bar, Resident #27 had a large BM on 05/27/25 and then there was no documentation she had a BM until 06/04/25 (eight days) at which time she had a small BM. They verified Resident #27's bowel elimination physician orders, and the facility policy were not followed as MOM should have been administered when she had no BM for three days and followed by bisacodyl suppository if the MOM was ineffective. Interview on 06/05/25 at 11:12 A.M. with ADON/RN #583 revealed she reviewed and noted per hospice notes Resident #27 had a BM on 5/20/25 and 06/01/25. She revealed Resident #27 may have had a BM when the hospice aide was in on 05/20/25 and 06/01/25 but verified this was not documented on the task bar to monitor Resident's #27's bowel elimination effectively. Interview on 06/05/25 at 12:45 P.M. with the DON and ADON/RN #583 revealed they were unsure how the nurse would know if Resident #27 had a BM if it was not put into the task bar for tracking purposes. They verified that even if Resident #27 had a BM on 05/20/25 and 06/01/25, the nurses still did not follow the bowel elimination policy or Resident #27's physician orders as Resident #27 still had gone from 05/15/25 till 05/20/25 (five days), and from 05/28/25 till 06/01/25 (five days) without a BM. Review of the facility policy labeled, Bowel Elimination, dated 04/15/25 revealed it was the policy to ensure that all residents were monitored for alterations in bowel elimination. The policy revealed all residents would be monitored each shift for bowel elimination and nursing staff would document all bowel movements each shift. The policy revealed if a resident went six shifts without a bowel movement the resident would be given a laxative on the seventh shift. If the resident had not had a bowel movement at the end of the eighth shift, then a rectal suppository would be given. The policy revealed if the resident had not had a bowel movement by the end of the ninth shift the physician would be notified for further orders.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to post oxygen safety signs per acceptable standards of nursing practice. This affected three (Residents #101, #103 and #105) out of three residents reviewed for respiratory care. There were eight (Residents #4, #5, #10, #13, #33, #101, #103 and #105) who received oxygen therapy. The facility census was 44. Findings include: Observation on 06/02/25 at 10:33 A.M. with Registered Nurse (RN) #567 revealed Residents #101 and #103 were in bed with oxygen being administered, and there were no oxygen safety signs posted within the room or at the entrances. Resident #105 was in a wheelchair next to the bed with oxygen being administered and there was no oxygen safety sign posted within the room or at the entrance. Interview at the time of the observation with RN #567 verified the findings. Review of the medical record for Resident #101 revealed an admission date of 05/10/25. Diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), emphysema and congestive heart failure (CHF). A physician order dated 05/10/25 indicated Resident #101 received oxygen at 4 LPM (liters per minute) via nasal cannula (NC) continuously. Review of the medical record for Resident #103 revealed an admission date of 05/28/25. Diagnoses included COPD, malignant neoplasm of the left lung lower lobe and heart failure. A physician order dated 05/30/25 indicated Resident #103 received oxygen at 2 LPM via NC continuously. Review of the medical record for Resident #105 revealed an admission date of 05/14/25. Diagnoses included COPD, CHF and chronic respiratory failure with hypoxia. A physician order dated 05/14/25 indicated Resident #105 received oxygen at 3 LPM via NC continuously. Review of the facility policy, Oxygen Administration, revised 05/06/15 revealed safe oxygen administration included placing an Oxygen in Use sign at the outside of the room entrance door and in a designated place on or over the resident's bed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review and facility policy review, the facility failed to perform adequate infection control practices during urinary catheter care for Resident #3. This affected one (Resident #3) out of two residents reviewed for urinary catheter care. There were two (Residents #3 and #36) who had urinary catheters. The census was 44. Findings include: Review of the medical record for Resident #3 revealed an admission date of 04/30/25. Diagnoses included neuromuscular dysfunction of the bladder, benign prostatic hyperplasia and end stage renal disease. The plan of care dated 04/30/25 indicated Resident #3 had a chronic urinary catheter which required catheter care and management. Observation on 06/03/25 at 10:03 A.M. with Certified Nursing Assistants (CNAs) #512 and #544 of urinary catheter care for Resident #3 revealed the resident in bed and both CNAs had donned gloves and gowns for enhanced barrier precautions. CNA #512 lowered Resident #3's pants and opened a soiled brief to expose the urinary catheter. CNA #512 used cleanser and disposable wipes to wash the genitals and catheter tubing before rolling Resident #3 to the left side toward CNA #544. While wearing the same soiled gloves, CNA #512 performed cleansing of the anal area then applied a clean brief after disposing of the soiled brief into a nearby trash can. While continuing to wear the same soiled gloves, CNA #512 pulled up the resident's pants, adjusted the pillow behind Resident #3's head, picked up another pillow and positioned it underneath Resident #3's feet, then pulled the sheets and blankets up over the resident followed by placing the call light within reach. CNA #512 removed the gown and right-hand soiled glove, placed it into the garbage, closed the garbage bag and picked it up with the left hand which was still covered by a soiled glove. CNA #512 left Resident #3's room carrying the garbage with the soiled gloved hand and unwashed right hand, walked down the hallway, entered the soiled utility room, and disposed of the garbage followed by removing the left glove and disposing of it. Across the hall from the soiled utility room was a hand washing sink where CNA #544 who had removed the gown and gloves in Resident #3's room had walked to and was seen performing hand washing. Interview at the time of the observation with CNA #512 verified waiting at the soiled utility room area to use the hand washing sink across the hall. CNA #512 stated it was routine practice to leave a resident room, come to the soiled utility room to dispose of garbage and then remove gloves and wash hands. CNA #512 confirmed the same gloves were worn throughout the procedure without changing gloves between body parts and were not removed completing hand hygiene before repositioning Resident #3 for comfort and safety. Review of the facility policy, Urinary Catheter Care, dated 04/22/13, revealed appropriate catheter care was provided to residents who had an indwelling catheter at a minimum of once per shift. Review of the facility policy, Hand Hygiene, updated 12/09/20, revealed hand hygiene was indicated when hands were visibly dirty, when hands were soiled with blood or other body fluids, after handling contaminated objects, and before applying and after removing personal protective equipment including gloves. The use of gloves was not a replacement for hand hygiene. Review of the facility policy, Personal Protective Equipment, updated 09/08/22, revealed hand hygiene was performed before donning gloves and after removal. Gloves were changed along with hand hygiene between clean and dirty tasks, when moving from one body part to another, and when gloves were heavily contaminated or torn.