

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley Liberty		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Tibbetts Wick Road Girard, OH 44420	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure food was stored, prepared and served in accordance with professional standards for food safety. This had the potential to affect 54 residents who received meals from the kitchen. The facility identified seven residents (Resident #19, #6, #8, #33, #70, #71 and #1) who received nothing by mouth (NPO). The facility census was 61. Findings Include: Observation on 09/15/25 at 9:54 A.M. of the dry food storage room in the main kitchen revealed the following food items were not dated with the date received: four one-gallon tubs of mayonnaise, one one-gallon Caesar salad dressing tub, one one-gallon Thousand Island dressing tub, two seven-pound five-ounce cans of jellied cranberry sauce, two six-pound cans of diced beets, one six-pound can of fruit cocktail, three six-pound cans of diced peaches, nine six-pound nine-ounce cans of diced apples, nine six-pound nine-ounce cans of diced pears, and six six-pound three-ounce cans of shredded sauerkraut. Observation on 09/15/25 at 9:55 A.M. of the main kitchen dry food storage revealed the following food items were open and wrapped in plastic wrap, not dated of when opened nor were they marked with an expiration date on the following items: a blueberry muffin mix, and a five-pound powdered sugar. Observation on 09/15/25 at 10:00 A.M. of the main kitchen walk-in freezer revealed a clear plastic bag of potato wedges opened to air with no label or date on the bag, sweet potato fries in a plastic bag open to air not dated or labeled, and four rainbow sherbets were scooped in plastic serving bowls were not labeled or dated. Interview on 09/15/25 at 10:03 A.M. with Chef Dietary Director (CDD) #656 verified the freezer items were not labeled, dated when opened, and food was open to freezer air. CDD #656 also verified the food in the main kitchen dry food storage cans were not dated with a date received. CDD #656 stated the food items should be dated and employees should date food upon arrival at the kitchen and when the package was opened. CDD #656 confirmed food should not be left open to air exposure. Observation on 09/16/25 at 12:14 P.M. of the dining room kitchen revealed a Purell Foodservice Sanitizer Multipurpose Cleaner was on the resident food preparation area next to food being served during meal service. Interview on 09/16/25 at 12:20 P.M. with Dietary Aid #657 revealed cleaning chemicals were to be stored away from the resident food preparation area and verified the Purell Foodservice Sanitizer All-purpose cleaner was stored by the resident food preparation area during meal service. Review of facility education titled, Food Safety and Sanitation, dated 07/21/25, revealed storage guidelines of food consisting of first-in first-out, labeling and expiration checks. Review of the facility document titled State of Ohio Food Inspection Report, dated 09/10/25, revealed under the section Conformance with Approved Procedures, the facility was out of compliance with critical control point investigation. Observation included toxic materials improperly identified, stored and used. The Purell bottle on prep counter, the bottle was moved and stored chemicals away from food prep surfaces. The document was signed by the [NAME] County Health District. Review of facility policy titled, Food Safety Requirements , Use and Storage of Food and Beverage, Food Procurement, undated, revealed the facility would prevent foodborne illness when food was received from the vendor and continued throughout the facility food handling process.		

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility administration failed to ensure an effective system was in place to maintain current cardiopulmonary resuscitation (CPR) certification for the licensed nurses for the highest practicable well being of all residents. This had the potential to affect all 61 residents residing in the facility. Findings include: Review of personnel files on [DATE] at 2:39 P.M. with Human Resources Director (HRD) #742 revealed Licensed Practical Nurse (LPN) #694's CPR (cardiopulmonary resuscitation) certification expired 03/2025 and was renewed on [DATE]. LPN #696's CPR certification expired [DATE] and was renewed on [DATE]. LPN #684's CPR certification expired 02/2025 and was renewed on [DATE]. LPN #690's CPR certification expired on 01/2025 and was renewed on [DATE]. LPN #697's CPR certification expired on 03/2024 and was renewed on [DATE]. LPN #691's CPR certification expired 06/2025 and was renewed on [DATE]. Registered Nurse (RN) #713's CPR certification expired 02/2024 and was renewed on [DATE]. LPN #686's CPR certification expired on 02/2025 and was renewed on [DATE]. The Director of Nursing (DON)'s CPR certification expired 07/2025 and was renewed [DATE]. Interview on [DATE] at 2:39 P.M. with HRD #742 verified the above findings. HRD #742 stated CPR certification was tracked and some lapses in the nurses CPR recertification were found through the tracking process. Interview on [DATE] at 9:34 A.M. with the DON revealed corporate takes care of CPR so the DON would not have been aware some nurses working in the facility did not remain current with CPR certification. The DON stated she took her CPR recertification through the American Heart Association and offered staff to attend if they wanted CPR certification. The DON stated they had very few codes in the facility. The DON confirmed staff who performed CPR were required to maintain current CPR certification. Review of the facility policy titled Cardiopulmonary Resuscitation Certification, updated [DATE], revealed it was the policy of the facility to ensure all direct care staff be trained and maintain certification for cardiopulmonary resuscitation. All nursing and direct care staff were required to maintain current CPR certification. This certification was a condition of employment. Failure to obtain certification within 30 days of expiration would result in removal from the work schedule and might lead to disciplinary action. This deficiency represents non-compliance investigated under Complaint Number 2584291.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility did not ensure transmission-based precautions were followed by staff during resident care. This affected two residents (#57 and #71) of five residents reviewed for infection control and had the potential to affect an additional nine residents (#33, #16, #35, #73, #6, #70, #8, #3, and #19) who resided on the 300 and 500 halls . The facility census was 61.Findings include:1. 1. Review of the medical record for Resident #57 revealed an admission date of 01/18/25 with diagnoses including spinal stenosis, atrial fibrillation, disease of larynx, malignant neoplasm of mouth, type two diabetes, hypertension, non-pressure chronic wound, urinary incontinence, and hematuria. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #57's cognition was intact. Resident #57 needed maximum assistance for toilet hygiene, bathing, and lower body dressing. Resident #57 needed moderate assistance to sit on the side of the bed, and was dependent on staff to stand and transfer from the bed to the chair, and to walk ten feet. Resident #57 was occasionally incontinent of urine and frequently incontinent of bowel. Resident #57 was on an antibiotic. Resident #57 received four days of restorative therapy that consisted of transfer and walking. Review of the care plan, date initiated 01/31/25 and revised 09/16/25, revealed Resident #57 was incontinent of bowel and bladder, needed assistance with toileting and peri care. Contact isolation due to pseudomonas in urine . Interventions included maintaining dignity of resident by maintaining comfort, good hygiene and intact skin. Check for incontinence episode upon rounds and as needed. Contact isolation. Peri care upon each incontinence episode and maintain turn schedule. Review of physician orders dated 08/26/25 revealed Resident #57 had an occupational therapy evaluation completed. Resident #57 was to be seen for 20 visits in 60 days for activities of daily living training, therapy exercise, and therapy activities. Review of a physician order dated 09/15/25 revealed Resident #57 was on Contact Isolation for psuedomonas of urine. Review of the facility document titled Occupational Therapy Treatment Encounter, start date 02/05/25, revealed Resident #57 had fall precautions and Contact Isolation precautions due to pseudomonas of urine and lower extremity skin sores. Review of the facility document titled Occupational Therapy Treatment Encounter, date of service 09/15/25, revealed Certified Occupation Therapy Assistant (COTA) #731 provided Resident #57 with skilled service that included bilateral upper extremities therapeutic exercise to increase strength, and range of motion. This included functional transfer from wheelchair level with minimal assistance, use pf four-wheel walker for support during dynamic activities, gross motor skills, and fine motor coordination. Observation on 09/15/25 at 2:00 P.M. of Resident #57 in his room standing behind a four-wheeled walker while COTA #731 provided hands on assistance holding on to Resident #57's gown and brief for support. COTA #731 was observed to make physical contact with Resident #57 without wearing gloves or a protective gown. Posted on the door to the resident's room was a Contact Isolation sign. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/15/25 at 2:02 P.M. with COTA #731 verified Resident #57's door had a Contact Isolation sign posted on the front of the door . COTA #731 stated it slipped her mind and verified she did not wear personal protective equipment such as a gown or gloves while touching Resident #57. COTA #57 stated she was standing behind Resident #57 while holding the back of Resident #57's gown and brief for support. Observation on 09/15/25 at 2:32 P.M. of certified nurse assistant (CNA) #732 revealed Resident #57's call light rang, CNA #732 knocked on Resident #57's door and entered the room. CNA #732 was observed not to put on a protective gown or gloves prior to entering Resident #57's room. Interview on 09/15/25 at 2:37 P.M. with CNA #732 revealed she assisted Resident #57 to the toilet and CNA #732 verified a Contact Isolation sign was posted on Resident #57's door and stated she did not wear protective gown or gloves because she was not aware. Interview on 09/15/25 at 2:39 P.M. with Licensed Practical Nurse (LPN) #239 revealed Resident #57 was on Contact Precautions because of urinary issues that needed an antibiotic. LPN #239 stated gloves, and a protective gown should be worn especially if contact/touch assist was needed to care for Resident #57. Interview on 09/18/25 at 9:57 A.M. with the Assistant Director of Nursing (ADON) #627 revealed Resident #57 needed Contact Isolation due to multi-drug-resistant organism. ADON #627, who also served as the facility Infection Preventionist, stated staff were to wear a protective gown and gloves and wash hands prior to entering Resident #57's room. Review of facility policy titled, Transmission Based Precautions, dated 06/15/19, revealed Contact Precautions was intended to prevent transmission of infectious agents which spread by direct contact with the resident or resident environment. Healthcare personnel caring for residents with Contact Precautions wear gowns and gloves for all interaction that involve contact with the resident or potentially contaminated areas in the residents environment. Putting on personal protective equipment upon room entry and discarding before exiting the room was done to contain pathogens. 2. Review of Resident #71's medical record revealed an admission date of 08/05/25 and a re-entry date of 09/12/25. Resident #71's diagnoses included ventilator associated pneumonia, emphysema, and resistance to multiple antimycobacterial drugs. Review of Resident #71's Quarterly MDS 3.0 assessment dated [DATE] included Resident #71 was cognitively intact. Resident #71 required substantial to maximal assistance with personal hygiene, toileting hygiene and bathing. Review of Resident #71's physician orders dated 09/13/25 revealed Droplet Isolation precautions related to MRSA (Methicillin resistant staphylococcus aureus), CRO (carbapenem-resistant organisms), MDRO (multi-drug resistant organism), every shift. Review of Resident #71's care plan dated 09/17/25 included Resident #71 had a respiratory infection related to carbapenems organism. Resident #71 would be free from signs and symptoms of infection by the review date of 11/10/25. Interventions included to maintain strict Droplet Isolation precautions with all services including therapies if warranted with all staff wearing PPE of gloves, gown, mask and face shield while remaining in a private room with no roommates. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/15/25 at 3:32 P.M. of Resident #71's room revealed Resident #71's room had a Droplet Isolation sign on the door and a plastic cart with PPE (personal protective equipment) was observed outside the entrance to Resident #71's room. Certified Nursing Assistant (CNA) #630 was observed in Resident #71's room, she was standing close to his bed and was talking to him. CNA #630 had not donned PPE such as not wearing face mask, isolation gown, gloves or face shield before she entered the room and began talking to Resident #71. Licensed Practical Nurse (LPN) #741 was observed in Resident #71's room adjusting his tube feeding and looking at his PEG (percutaneous endoscopic gastrostomy) tube. LPN #741 had gloves on but was not wearing a face mask, face shield, or isolation gown. Two visitors were observed in Resident #71's room and neither visitor had a face mask, face shield, isolation gown or gloves on. The visitors were sitting in chairs near Resident #71's bed. When asked if LPN #741 saw the Droplet Isolation sign on Resident #71's door and the plastic cart with PPE supplies LPN #741 stated she saw the Droplet Isolation sign, did not know why Resident #71 was on Droplet Precautions, but thought it was due to MRSA. LPN #741 confirmed she was not wearing a face mask, face shield or isolation gown and she should be. CNA #630 walked out of Resident #71's room and confirmed she was not wearing a face mask, face shield, isolation gown or gloves. CNA #630 did not know why Resident #71 was on Droplet Precautions and stated I was only talking to him. Interview on 09/15/25 at 3:54 P.M. of the Director of Nursing (DON) and Assistant Director of Nursing/ Infection Preventionist (ADON/IP) #627 revealed they were told LPN #741, CNA #630 and two visitors were in Resident #71's room and were not wearing appropriate PPE. ADON/IP #627 stated they should have donned PPE because Resident #71 was on Droplet Precautions for CRO. Review of the facility policy titled Transmission-Based Precautions revised 06/05/19 included Droplet Precautions was intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (for example, respiratory droplets that were generated by a resident who was coughing, sneezing, or talking). Make decisions regarding private room on a case-by-case basis after considering infections risks to other residents in the room and available alternatives. Healthcare personnel wear a mask for close contact with infectious resident.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure Resident #28's Power of Attorney (POA) was notified of a change of condition. This affected one resident (#28) of three residents reviewed for change of condition. The facility census was 61. Findings include: Review of Resident #28's medical record revealed an admission date of 06/26/23 and diagnoses of cerebral infarction, hemiplegia affecting the left nondominant side and congestive heart failure. Review of Resident #28's care plan revised 06/30/25 included Resident #28 was incontinent of bowel and bladder, had weakness, fatigue, and needed assistance with toileting and peri care related to diagnoses of left sided hemiparesis on the non dominant side, cerebral infarction and other diagnoses. Resident #28 to be less incontinent of bowel and/or bladder over the next 90 days. Interventions included to monitor for episodes of incontinence and continence; monitor for signs of urinary infections such as odors, concentrated urine etcetera and report to the nurse, physician. Review of Resident #28's Annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #28 was cognitively intact. Resident #28 was dependent for toileting hygiene and required partial to moderate assistance with personal hygiene. Resident #28 was frequently incontinent of urine. Review of Resident #28's progress notes dated 08/27/25 at 4:18 P.M. revealed Physician #735 gave new orders for a urinalysis and urine culture and sensitivity. There was no evidence documented to reflect Resident #28's POA was notified of the order. Review of Resident #28's physician orders dated 08/27/25 revealed urinalysis and urine culture and sensitivity, discontinue order once specimen was obtained. Review of Resident #28's progress notes dated 08/28/25 to 09/03/25 revealed no evidence Resident #28's POA was notified of physician orders to collect a urinalysis for culture and sensitivity testing. Review of Resident #28's physician orders dated 09/03/25 at 7:17 A.M. revealed urine for urinalysis and urine culture and sensitivity, every shift, discontinue once obtained. Review of Resident #28's progress notes dated 09/04/25 at 10:48 P.M. included Resident #28 was straight cathed for urinalysis and urine culture and sensitivity and 75 cc of dark yellow urine was obtained. There was no evidence documented to reflect Resident #28's POA was notified. Review of Resident #28's lab report revealed Resident #28's urine was collected on 09/05/25 at 12:00 P.M., was received on 09/05/25 at 3:11 P.M. and reported on 09/09/25 at 2:39 P.M. Resident #28's final report included greater than 100,000 CFU (colony forming units) per milliliter of Providencia stuartii (gram-negative bacterium, causes healthcare associated infections). Review of Resident #28's progress notes dated 09/09/25 at 3:18 P.M. revealed Resident #28's final report for the urinalysis and urine culture and sensitivity was sent to Physician #735 and was awaiting response. There was no evidence documented to reflect Resident #28's POA was notified of the result. Review of Resident #28's progress notes dated 09/10/25 at 2:18 A.M. revealed new orders for cefpodoxime 100 mg, two times a day for seven days for UTI (urinary tract infection), if no allergies. There was no evidence documented to reflect Resident #28's POA was notified of the order. Interview on 09/15/25 at 12:04 P.M. with POA #736 revealed she was Resident #28's daughter and was also her POA. POA #736 stated she was not called by the facility and notified Resident #28 had a potential urinary tract infection or notified Resident #28 had a urinary tract infection. POA #736 indicated she was upset she was not contacted. Observation on 09/16/25 at 3:37 P.M. of Resident #28 revealed she was sitting in a chair in her room, was agreeable to have a conversation and answered questions appropriately. Resident #28 stated she was receiving antibiotics now and was having pain with urination before she started getting the antibiotics. Resident #28 indicated she told a nurse she was having discomfort when she went to the bathroom and now I am getting antibiotics. Resident #28 confirmed her daughter was POA and the facility was to keep her daughter informed about her care. Interview on 09/18/25 at 3:47 P.M. with the Director of Nursing (DON) verified no documented evidence Resident #28's daughter had been notified of the residents change of condition, urinalysis results and treatment with antibiotics.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure assistance from staff was provided to maintain good hygiene for Resident #3. This affected one resident (Resident #3) out of three residents reviewed for assistance with activity of daily living (ADL). The facility census was 61. Findings include: Review of Resident #3's medical record revealed an admission date of 05/15/24 and a re-entry date of 12/24/24. Resident #3's medical diagnoses included multiple sclerosis, acute respiratory failure with hypoxia, quadriplegia, contracture of joint and flaccid neuropathic bladder. Review of Resident #3's Quarterly Minimum Data Set 3.0 assessment, dated 08/12/25, revealed Resident #3 was cognitively intact. Resident #3 had impairment of both sides of the upper and lower extremities. Resident #3 was dependent for Activity of Daily Living's (ADLs) including showering/bathing, personal hygiene and for bed mobility. Review of Resident #3's care plan, revised 05/16/25, revealed Resident #3 needed assistance with ADLs related to a diagnosis of Multiple Sclerosis. There were no specific ADL interventions listed regarding showering/bathing or hygiene. Observation on 09/18/25 at 8:48 A.M. of Resident #3 revealed he was lying in bed on his left side while watching television. The fingers on both hands were clenched tightly up against the palm of his hands, and his legs were contracted up towards his chest. Resident #3 was alert, oriented to person, place, time and situation and able to answer questions. There was a pervasive, sweet and unpleasant odor in the room. Interview on 09/18/25 at 8:51 A.M. with Licensed Practical Nurse (LPN) #684 revealed Resident #3's hands were always clenched. LPN #684 indicated Resident #3 always had that smell, and it could be related to a yeast infection he had in his [NAME] area, but she was not sure. Observation on 09/18/25 at 9:10 A.M. of Resident #3 with LPN #684 revealed he was lying in bed and a sweet, unpleasant odor was noticed when his room was entered. Certified Nursing Assistant's (CNA)'s #631, #634 and #740 were preparing to assist Resident #3 with a bed bath. CNA #740 stated this was not Resident #3's shower day but they were going to give him a bed bath because an odor was noted in his room. Resident #3's legs were bent up towards his chest and his hands were in a clenched position. LPN #684 was called out of Resident #3's room by another staff member, so she walked out of Resident #3's room. Upon closer observation of Resident #3's hands, it was observed that Resident #3's fingernails were approximately a half inch long, yellow in color and underneath each nail was brown material. CNA #740 confirmed Resident #3's fingernails were long, yellow in color with brown material under them. CNA #740 indicated she never cut his nails and would tell a nurse about them being long. CNA's #631, #634 and #740 proceeded to provide Resident #3's morning care and while washing his hands a moderate amount of yellow material was noted on the wash cloth. CNA #740 stated the yellow material smelled and that was where the sweet, unpleasant odor was coming from. CNA's #631, #634 and #740 confirmed Resident #3's hands were not being kept properly clean and there was a smell noted. Interview on 09/22/25 at 12:40 P.M. with Restorative Registered Nurse (RRN) #719 revealed there should always be towel rolls placed in Resident #3's hands due to the clenching and she would make sure going forward the towel rolls would be placed. RRN #719 confirmed Resident #3's fingernails were about a half inch long with some brown material underneath the nails. RRN #719 stated Resident #3 was a two person assist for hand care due to his contractures and another staff member assisted her to clean and trim Resident #3's fingernails. RRN #719 confirmed Resident #3 had an odor, and stated he is so moist, but she was not sure what the source of the odor was.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to ensure thorough post-fall investigations were completed to identify, evaluate and analyze risks, implement appropriate interventions, and monitor for effectiveness of interventions to mitigate risk of subsequent falls for Resident #34. This affected one resident (Resident #34) out of three residents reviewed for falls. The facility census was 61. Findings include: Review of Resident #34's medical record revealed an admission date of 07/11/25 with diagnoses including ataxic gait, dementia, macular degeneration and Meniere's Disease. Review of Resident #34's Fall Risk Evaluation dated 07/16/25 revealed Resident #34 was at high risk for falls. Review of Resident #34's admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #34 had severe cognitive impairment. Resident #34 had upper extremity impairment on both sides. Resident #34 was dependent for toileting hygiene, required partial to moderate assistance with personal hygiene, and required substantial to maximal assistance with bathing and dressing. Resident #34 had a fall in the last month prior to admission to the facility. Review of Resident #34's care plan dated 07/23/25 included Resident #34 had a fall on 07/20/25 with no injury due to poor balance, poor communication, comprehension, psychoactive drug use, unsteady gait, and Meniere's Disease. Resident #34 would resume usual activities without further incident through the review date. Interventions included to check range of motion, continue interventions on the at-risk plan for no apparent acute injury, determine and address causative factors of the fall, monitor, document and report as needed for 72 hours to the physician for signs and symptoms of pain, bruises, change in mental status, and Physical Therapy consult for strength and mobility. Review of the facility incident log dated 08/21/25 at 4:00 P.M. revealed Resident #34 was found on the floor. Review of Resident #34's progress notes dated 08/21/25 at 10:32 P.M. revealed Resident #34 was found on the floor in front of her recliner. Resident #34 used the button incorrectly causing the chair to rise and she slid to the floor. Resident #34 had no visible injuries and stated she had the same pain in her knee that she had. ROM (range of motion) normal per resident. Assisted to bed. Physician #735 and Resident #34's daughter were notified. There was indication a new intervention was implemented to reduce reoccurrences. Review of Resident #34's Interdisciplinary Fall Incident Investigation, review date 08/22/25, revealed Resident #34 had a fall on 08/21/25 at 4:00 P.M. There were no witnesses to the fall. Resident #34 was assisted to bed, neurological checks were initiated, range of motion and vital signs were within normal limits. There were no vital signs documented. While passing by Resident #34's room an aide (unidentified) found her on the floor in front of her chair. Resident #34 stated she used a button on her chair and it changed position causing her to slide to the floor. Resident #34 stated she pushed the wrong button on her recliner and instead of going up and back, she slid down to the floor. Resident #34 denied hitting her head and complained of knee pain which she had previous to the fall. The investigation indicated Resident #34's care plan was reviewed and updated. Review of Resident #34's progress notes dated 08/28/25 at 4:51 P.M. revealed Resident #34 was observed on the floor. Resident #34 was sitting in an upright position on the floor in front of her recliner. A head-to-toe assessment was completed and a 3.0 cm by 2.5 cm goose egg was found on top of Resident #34's head. Vital signs were obtained: blood pressure 164/79, temperature 97.7 Fahrenheit, heart rate 74, respirations 18 and Resident #34's oxygen saturation was 97 percent on room air. Resident #34 was one assisted into a wheelchair and taken to the dining area for supper. There was no evidence Resident #34 had a new individualized fall intervention implemented. Review of the facility incident log dated 08/28/25 did not reveal evidence Resident #34 experienced a fall on 08/28/25 at 4:51 P.M. Review of Resident #34's progress notes dated 08/28/25 at 6:12 P.M. included Resident #34's physician ordered her sent to the Emergency Department for evaluation due to the size of the goose (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/22/2025
NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley Liberty		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Tibbetts Wick Road Girard, OH 44420	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	egg on her head. Resident #34's daughter was updated. Review of Resident #34's fall investigations provided by the facility did not include a fall investigation for the fall on 08/28/25 at 4:51 P.M. Review of the facility incident log dated 09/12/25 revealed Resident #34 had a witnessed fall on 09/12/25 at 3:30 P.M. Review of Resident #34's progress notes dated 09/12/25 at 3:30 P.M. included a visitor notified the nurse that Resident #34 was sliding out of her recliner. Resident #34 was observed lowering herself to the floor, sliding down the recliner. Resident #34 denied pain and stated she was going to the bathroom to brush her teeth but couldn't stand up. Vital signs were checked and Resident #34 was assisted into bed. No bruising was noted to Resident #34's bottom. All safety measures in place and Resident #34 was placed on every two hour checks for 24 hours. Review of Resident #34's Interdisciplinary Fall Incident Investigation included the date of the witnessed fall was 09/12/25 at 5:45 P.M. (the progress notes and incident log stated the time was 3:30 P.M.) and the review date was 09/14/25. The Investigation report included the fall information from Resident #34's progress note on 09/12/25 at 3:30 P.M. Resident #34 was provided a quiet environment for rest, all safety measures in place, frequent checks, one-to-one interventions. Resident #34's care plan was reviewed and updated. Further review of Resident #34's care plan, last revised on 08/11/25, revealed no notation of falls occurring on 08/21/25, 08/28/25 and 09/12/25, nor any updates to interventions after 07/23/25 to try to prevent subsequent falls. Interview on 09/22/25 at 1:56 P.M. with Licensed Practical Nurse (LPN) #685 revealed Resident #34 was incontinent, confused at times, and sometimes would ask to go to the bathroom. LPN #685 stated Resident #34 required the assistance of one staff member and used a front wheeled walker. Observation on 09/22/25 at 2:06 P.M. with CNA #743 and CNA #744 revealed Resident #34 was lying in bed with her eyes closed and appeared to be sleeping. Certified Nursing Assistant (CNA) #743 stated Resident #34 asked to be toileted so CNA #743 assisted her for toileting then assisted her to bed using a gait belt and a wheelchair. CNA #743 indicated Resident #34 often asked to be toileted. CNA #744 stated she worked second shift and knew Resident #34 well. When asked if Resident #34 was at risk for falls, CNA's #743 and #744 stated Resident #34 was not a fall risk so she did not have fall mats by her bed. Interview with LPN #685 on 09/22/25 at 2:07 P.M. indicated she did not think Resident #34 was a fall risk, but would check her orders. LPN #685 checked Resident #34's orders and stated she was a one assist for transfers, wore non skid socks and an order dated 09/12/25 revealed she was on two hour checks for falls. LPN #685 indicated Resident #34 might be a fall risk. Interview on 09/22/25 at 2:39 P.M. of the Director of Nursing (DON) revealed a fall risk assessment was not and did not need completed after every fall for Resident #34. The DON stated a team huddle was completed after a resident fall including Resident #34 and the falls were reviewed. The DON indicated that after a fall happened, new person centered interventions were added to the resident's care plan and aide tasks for Resident #34 so the care staff knew what her needs were to prevent falls. The DON stated a fall paper packet was completed after a fall, but that fall paper packet was not included as part of the resident medical record. Review of the facility policy titled Falls, Incidents, undated, included when a resident was found on the floor, the facility was obligated to investigate to determine how he/she got there, and to put into place an intervention to prevent this from happening again. Once a fall incident occurred, the name of any witnesses and their accounts of the accident or incident, and the immediate corrective action taken must be included on the Incident Report. A nurse progress note would be completed and would include interventions identified to reduce reoccurrences, the resident's response to the incident and interventions.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of lab reports the facility failed to ensure Resident #28 received appropriate care and services to assess for and treat a urinary tract infection (UTI). This affected one resident (Resident #28) out of four residents reviewed for UTI. The facility census was 61. Findings include: Review of Resident #28's medical record revealed an admission date of 06/26/23 and diagnoses of cerebral infarction, hemiplegia affecting the left nondominant side and congestive heart failure. Review of Resident #28's care plan revised 06/30/25 included Resident #28 was incontinent of bowel and bladder, had weakness, fatigue, and needed assistance with toileting and peri care related to diagnoses of left sided hemiparesis on the non dominant side, cerebral infarction and other diagnoses. Resident #28 to be less incontinent of bowel and, or bladder over the next 90 days. Interventions included to monitor for episodes of incontinence and continence; monitor for signs of urinary infections such as odors, concentrated urine etcetera and report to the nurse, physician. Review of Resident #28's Annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #28 was cognitively intact. Resident #28 was dependent for toileting hygiene and required partial to moderate assistance with personal hygiene. Resident #28 was frequently incontinent of urine. Review of Resident #28's progress notes dated 08/27/25 at 4:18 P.M. revealed Physician #735 gave new orders for a urinalysis and urine culture and sensitivity. Review of Resident #28's physician orders dated 08/27/25 revealed urinalysis and urine culture and sensitivity, discontinue order once specimen was obtained. Review of Resident #28's progress notes dated 08/29/25 at 4:49 A.M. revealed two attempts were made to obtain Resident #28's urine for urinalysis and culture and sensitivity via straight catheter and white sludge clogged the catheter both times. There was no evidence Physician #735 was notified of the failed attempts to obtain urine for a urinalysis and culture and sensitivity. Review of Resident #28's medical record including progress notes and Medication and Treatment Administration Records dated 08/29/25 through 09/03/25 did not reveal evidence of attempts to collect Resident #28's urine or notification of Physician #735 of any failed attempts to collect Resident #28's urine for urinalysis and culture and sensitivity as ordered on 08/27/25. Review of Resident #28's physician orders dated 09/03/25 at 7:17 A.M. revealed urine for urinalysis and urine culture and sensitivity, every shift, discontinue once obtained. Review of Resident #28's progress notes dated 09/04/25 at 5:42 A.M. revealed urinalysis and urine culture and sensitivity every shift, discontinue once obtained, was unable to be obtained this shift. There was no evidence Physician #735 was notified that Resident #28's urine was unable to be obtained and no reason why Resident #28's urine was unable to be obtained. Review of Resident #28's progress notes dated 09/04/25 at 10:48 P.M. included Resident #28 was straight cathed for urinalysis and urine culture and sensitivity and 75 cc of dark yellow urine was obtained. Review of Resident #28's lab report revealed Resident #28's urine was collected on 09/05/25 at 12:00 P.M., was received on 09/05/25 at 3:11 P.M. and reported on 09/09/25 at 2:39 P.M. Resident #28's final report included greater than 100,000 CFU (colony forming units) per milliliter of Providencia stuartii (gram-negative bacterium, causes healthcare associated infections). Review of Resident #28's progress notes dated 09/09/25 at 3:18 P.M. revealed Resident #28's final report for the urinalysis and urine culture and sensitivity was sent to Physician #735 and was awaiting response. Review of Resident #28's progress notes dated 09/10/25 at 2:18 A.M. revealed new orders for cefpodoxime 100 milligrams, two times a day for seven days for UTI (urinary tract infection), if no allergies. This was 14 days after Physician #735 ordered Resident #28's urine to be collected for a urinalysis and urine culture and sensitivity. Observation on 09/16/25 at 3:37 P.M. of Resident #28 revealed she was sitting in a chair in her room, was agreeable to have a conversation and answered questions appropriately. Resident #28 stated she was receiving antibiotics now and was having pain with urination before she started getting the antibiotics. Resident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#28 indicated she told a nurse she was having discomfort when she went to the bathroom and now I am getting antibiotics. Interview on 09/17/25 at 2:24 P.M. with Nurse Practitioner (NP) #733 revealed Resident #28 received long term care at the facility and Physician #735 usually cared for residents receiving long term care. NP #733 stated she was not aware Physician #735 ordered Resident #28 to have a urinalysis and urine culture and sensitivity collected on 08/27/25, and if there was a problem collecting the specimen either she or Physician #735 should have been notified. NP #733 stated it was a long time to wait from 08/27/25 through 09/04/25 to collect Resident 328's urine specimen, especially if there was something going on. Interview on 09/18/25 at 12:19 P.M. of Physician #735 revealed he received a lot of phone calls and did not remember details regarding Resident #28's urine specimen orders on 08/27/25 and 09/03/25. Physician #735 stated he had no idea why Resident #28's urine was not collected until 09/04/25, but it absolutely should have been collected before then. Interview on 09/18/25 at 3:47 P.M. of the Director of Nursing (DON) revealed she was not sure why it took eight days for Resident #28's urine to be collected and sent to the lab for a urinalysis and urine culture and sensitivity. The DON stated she was not in the facility that week.		