

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: 365376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER Ohio Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5280 State Routes 62 68 Ripley, OH 45167	
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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure dented cans were discarded, food items were dated and labeled, and kitchen staff washed their hands utilizing proper technique. These failures had the potential to affect all residents who received meals from the dietary department. Findings included: A facility policy titled, Food Storage, revised 11/2024, indicated, Policy Statement- Food shall be received and stored in a manner that complies with safe food handling practices. The section titled, Policy Interpretation and Implementation revealed, 5. Dry foods will be labeled and dated. Such foods will be rotated using first in - first out system. 6. All foods stored in the refrigerator and freezer will be covered, labeled and dated. a. Refrigerated, ready to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or date by which the food shall be consumed or discarded when held at 41 degrees F [Fahrenheit] for a maximum of 7 days. The date of preparation counted as day 1. b. Refrigerated, ready to eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held over 24 hours, to indicate the date or date by which the food shall be consumed or discarded when held at 41 degrees F for a maximum of 7 days. The date of preparation shall be counted as day one and date marked may not exceed a manufacturer's use by date if the manufacture determined the use by date based on food safety. A facility policy titled, Handwashing/Hand Hygiene Policy Interpretation and Implementation, reviewed 04/28/2025, indicated, Washing Hands 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use a towel to turn off the faucet. A concurrent observation and interview on 08/18/2025 at 9:25 AM, revealed the Dietary Supervisor washed her hands for about eight seconds prior to entering the dry pantry. The Dietary Supervisor stated she did not know why she washed her hands in haste, she was just in a hurry, and she knew better. The Dietary Supervisor stated the expectation was to wash hands for at least 15 seconds. The Dietary Supervisor stated the risk to residents was foodborne illness. A concurrent observation and interview on 08/18/2025 at 9:27 AM revealed two 50-ounce tomato soup cans in the dry pantry area. One 50-ounce tomato soup can was dented and the other was dented and breached. The Dietary Supervisor stated the spillage from the breached can looked like mold. A concurrent observation and interview on 08/18/2025 at 9:33 AM revealed six meat patties stored in an unlabeled foam container in a refrigerator. The Dietary Supervisor stated the meat patties may have been leftovers from a meal served, the facility held leftovers for seven days, and the expectation was to count the day of opening as day one. The observation also revealed a clear plastic bag with white onion slices and a use by date of 08/20/2025, but no preparation date. A concurrent observation and interview on 08/18/2025 at 9:38 AM revealed an opened, unsealed box of frozen pizza slices; an unsealed clear plastic bag containing five pounds of garlic bread sticks that were not labeled and not dated; and egg patties that were not dated or labeled. The Dietary Supervisor stated the expectation was that all food items be sealed with (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	open and use-by dates. A concurrent observation and interview on 08/20/2025 at 9:26 AM revealed [NAME] #17 did not wash with soap for at least 15 seconds. [NAME] #17 stated she got nervous, and she was supposed to turn on the water, use soap, scrub for 20 seconds, rinse thoroughly, grab a paper towel, dry her hands, and use the paper towel to shut off the water. [NAME] #17 stated not washing hands properly could make residents sick. A concurrent observation and interview on 08/20/2025 at 9:28 AM revealed Dietary Aide #16 washed her hands, shut off the water with her hands, and grabbed a paper towel to dry her hands. Dietary Aide #16 stated she was supposed to leave the water running and use a paper towel to shut off the water after drying her hands. Dietary Aide #16 stated she did not know why she did not use paper towels to shut off the water. She further stated not washing hands properly could make residents sick. During an interview on 08/20/2025 at 2:10 PM, the Administrator stated the expectation for food labeling and storage for the kitchen staff was that they followed regulations and that all food was stored and labeled according to regulations and guidelines. The Administrator stated all kitchen staff were responsible for the proper labeling and storage of food items. The Administrator stated it was important to label and store food items properly to ensure palatability and food safety, and, if food was not labeled and stored properly, there may be potential for foodborne illness. The Administrator stated the expectation for kitchen staff when washing hands was that they should turn the water on, use hot water, use soap, scrub for 20 seconds, rinse thoroughly, dry hands with a clean paper towel, and use a clean dry paper towel to turn off faucets. The Administrator stated she did not know why kitchen staff did not properly wash their hands during the survey, and it was important for staff to wash hands properly to avoid illness. The Administrator stated she expected dented cans to be properly disposed. The Administrator further stated that dented cans were kept in the manager's office until the damaged items could be returned to their vendor.		

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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 follow physician's orders for supplemental oxygen administration for 1 (Resident #41) of 5 residents reviewed for oxygen use. Findings included: A facility policy titled, Policy and Procedure for the Administration of Oxygen Therapy, reviewed 11/2024, revealed, Procedure 1. Oxygen will be administered in accordance with physician's order. 2. Nurse should verify order prior to administering oxygen. An admission Record revealed the facility admitted Resident #41 on 03/27/2019. According to the admission Record, the resident had a medical history that included diagnoses of heart disease, mild intermittent asthma, and personal history of COVID-19. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2025, revealed Resident #41 had a short- and long-term memory problem and severely impaired cognitive skills for daily decision-making per a Staff Assessment of Mental Status (SAMS). The MDS revealed Resident #41 received supplemental oxygen therapy while a resident of the facility. Resident #41's Care Plan Report included a problem statement, initiated 05/10/2023, that indicated the resident had a potential for altered respiratory status related to allergic rhinitis and asthma. An intervention initiated on 05/10/2023 directed staff to administer supplemental oxygen per medical doctor (MD) orders. Resident #41's Medication Review Report, dated 08/21/2025, included an order started on 06/03/2024 to administer supplemental oxygen at two liters per minute (LPM) per nasal canula (flexible tubing fitted in the nostrils), routinely every day and night shift for cough and congestion. An observation on 08/18/2025 at 12:33 PM revealed Resident #41 was in bed receiving supplemental oxygen by way of a nasal canula at a rate of 1.5 LPM. An observation on 08/19/2025 at 11:13 AM revealed Resident #41 was in bed receiving supplemental oxygen by way of a nasal canula at a rate of 1.5 LPM. An observation on 08/20/2025 at 8:00 AM revealed Resident #41 was in bed receiving supplemental oxygen by way of a nasal canula at a rate of 1.5 LPM. During an interview on 08/18/2025 at 12:33 PM, Registered Nurse (RN) #13 reviewed Resident #41's electronic medical record (EMR) and stated the resident should be on continuous supplemental oxygen at a rate of 2 LPM. During a concurrent observation and interview on 08/20/2025 at 8:06 AM, State Tested Nurse Aide (STNA) #15 looked at Resident #41's oxygen concentrator and stated, Right now it [the oxygen concentrator] is on at 1.5 LPM. The observation revealed STNA #15 exited the resident's room and did not tell the nurse about Resident #41's oxygen flow rate. During a concurrent observation and interview on 08/20/2025 at 8:59 AM, Licensed Practical Nurse (LPN) #14 checked Resident #41's oxygen concentrator and stated the setting was below 2 LPM but above 1.5 LPM. During an interview on 08/21/2025 at 4:01 PM, the Administrator stated she expected staff to follow orders for oxygen administration.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify hospice services of a significant change in a resident's physical, mental, social, or emotional status for 1 (Resident #129) of 1 resident reviewed for hospice services. Specifically, Resident #129 fell due to a seizure on 07/27/2025, and the facility did not notify hospice until 07/28/2025. Findings included: An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/28/2025, revealed Resident #129 was admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE]. The MDS indicated the resident had a medical history that included diagnoses of non-traumatic brain dysfunction and diabetes mellitus. Resident #129 had a short- and long-term memory problem and severely impaired cognitive skills for daily decision-making per a Staff Assessment of Mental Status (SAMS). The MDS indicated Resident #129 received hospice services while a resident of the facility. Resident #129's Order Summary Report, listing active orders as of 08/21/2025, revealed an order dated 09/03/2024 to admit the resident to hospice services. Resident #129's Care Plan Report included a focus area, initiated 09/27/2024, that indicated the resident had potential for or a decline in condition and the resident received hospice services. An intervention initiated 09/27/2024 directed staff to keep family and hospice informed. During an interview on 08/21/2025 at 2:14 PM, the Hospice Case Manager stated Resident #129 was admitted to hospice services on 09/03/2024. The Hospice Case Manager stated an incident occurred on Sunday, 07/27/2025, that resulted in a shoulder injury to the resident. The Hospice Case Manager stated the facility did not notify hospice about the incident until the next day on Monday, 07/28/2025. The Hospice Case Manager stated hospice had a 24-hour phone contact, and the expectation was that the facility would have reported the incident immediately. The Hospice Case Manager stated that following this incident, she reminded Licensed Practical Nurse (LPN) #2 that hospice had a 24-hour contact number. During an interview on 08/21/2025 at 10:40 PM, LPN #19 stated Resident #129 experienced a seizure on 07/27/2025 and fell on their right shoulder, causing a shoulder injury. LPN #19 stated she was performing a medication pass, and when she noticed Resident #129 was having a seizure, she dropped what she was doing to assist the resident. LPN #19 stated she notified the physician, family, and the unit manager, but did not notify the hospice provider, because she was not aware at the time that the resident received hospice services. LPN #19 stated her main concern at that moment was to provide care to Resident #129 to stabilize the resident. LPN #19 stated she knew the hospice provider should have been notified, and she believed the unit manager notified the hospice provider the next morning. During an interview on 08/22/2025 at 10:33 AM, the Director of Nursing (DON) stated she did not think the attending nurse, LPN #19, was aware Resident #129 was admitted to hospice. The DON stated the electronic medical record (EMR) was unavailable at the time due to a change in the facility's ownership, and nursing staff were working from the resident's paper charts, which had limited documentation. The DON stated the expectation would have been to notify the hospice provider immediately after the resident was stable. The DON stated the unit manager brought it to her attention that hospice was not notified until the following day.		

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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 ensure hand hygiene occurred between glove changes for 1 (Resident #32) of 1 residents observed during wound care and the facility failed to store oxygen equipment appropriately when not in use for 1 (Resident #61) of 5 residents reviewed for respiratory services. Findings included: A facility policy titled, Handwashing/Hand Hygiene Policy Interpretation and Implementation, dated 04/28/2025, did not address hand hygiene between glove changes. An admission Record indicated the facility admitted Resident #32 on 05/13/2025. According to the admission Record, the resident had a medical history that included diagnoses of obesity and chronic pain syndrome. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2025, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #32 had one stage 2 pressure ulcer that was present upon admission. Resident #32's Care Plan Report included a focus area, revised 05/20/2025, that indicated the resident had impaired skin integrity. Interventions directed staff to use enhanced barrier precautions related to wounds and to monitor for signs and symptoms of infection. On 08/19/2025 at 2:26 PM, observations of wound care for Resident #32 revealed that Licensed Practical Nurse (LPN) #2 entered the resident's room with gloves on then put another pair of gloves over top of the first pair. The observation revealed LPN #2 cleansed Resident #32's wound with normal saline, patted the wound dry, and applied a skin-protectant and packing material to the wound. The observation revealed that when LPN #2 removed her gloves both pairs of gloves came off. The observation revealed LPN #2 got another pair of gloves and put them on without doing hand hygiene. The observation revealed after applying a dressing to the wound, LPN #2 removed her gloves again and put on new gloves without doing hand hygiene. The observation revealed LPN #2 removed all the supplies, threw the supplies away with her gloves on, and then washed her hands. During an interview on 08/19/2025 at 2:40 PM, LPN #2 stated she used hand sanitizer before she entered the room, and she put on two pairs of gloves. LPN #2 stated when both pairs of gloves came off, she did not do hand hygiene prior to putting on more gloves, but she should have. LPN #2 stated she should have done hand hygiene between each glove change. During an interview on 08/22/2025 at 10:34 AM, the Director of Nursing (DON) stated hand hygiene should occur after staff touched a dirty area, and staff should take off their gloves, perform hand hygiene, and then put on new gloves. The DON stated gloves should be changed anytime they were soiled and hand hygiene should occur in between all glove changes. During an interview on 08/22/2025 at 11:12 AM, the Administrator stated hand hygiene should be done in between glove changes for infection control reasons		