

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley-Boardman		STREET ADDRESS, CITY, STATE, ZIP CODE 7148 West Blvd Youngstown, OH 44512	

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>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567</p> <p>Based on observation, interview, medical record review, and review of the facility policy, the facility failed to ensure appropriate hand hygiene was performed during medication administration for Residents #21 and #44 and failed to ensure appropriate identification of resident transmission-based precautions status for Resident #44. This affected two residents (#21 and #44) of three residents who were observed during medication administration and had the potential to affect all 41 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #21 revealed an initial admitted [DATE] and a re-entry date of 11/06/24. Diagnoses included acute and chronic respiratory failure with hypoxia, active COVID-19 infection upon initial admission, chronic obstructive pulmonary disease (COPD), asthma, and presence of a cardiac pacemaker.</p> <p>Review of the most recent comprehensive Minimum Data Set (MDS) assessment completed on 09/07/24 revealed Resident #21 had intact cognition. High-risk medications included antidepressants, antibiotics, and antiplatelets.</p> <p>Review of the physician orders revealed an order dated 11/07/24 for Symbicort Inhalation Aerosol 160-4.5 micrograms per actuation (mcg/act)(Budesonide-Formoterol Fumarate Dihydrate), two puffs inhaled orally one time a day related to COPD.</p> <p>Observation on 11/12/24 from 8:40 A.M. to 8:43 A.M. revealed Licensed Practical Nurse (LPN) #331 completed medication administration for Resident #29 and exited Resident #29's room without performing hand hygiene. During the observation, LPN #331 proceeded to open the drawer to the medication cart, remove an inhaler labeled for Resident #21, used her laptop to document medication administration for Resident #29, poured water in a cup, and brought the cup of water, empty cup, and inhaler into the room of Resident #21 without performing hand hygiene. At 8:43 A.M., LPN #331 administered one puff of Symbicort Inhalation Aerosol (the first of the two ordered puffs was administered prior to the administration of Resident #21's medications), then assisted Resident #21 in taking water into his mouth by cup and instructed him to rinse and spit in the empty cup she held to his mouth. No hand hygiene was performed before or after administration of Resident #21's inhalation medication.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/12/24 at 9:00 A.M. with LPN #331 confirmed she had not performed hand hygiene between administering medications to Resident #29 and Resident #21, and hand hygiene should be performed between providing medications to each resident.</p> <p>Review of the facility policy titled Medication Administration, last revised 06/18/24, revealed staff were to wash their hands prior to medication administration per facility protocol</p> <p>Review of the facility policy titled Hand Hygiene, dated June 2023, revealed staff were to perform hand hygiene between resident contacts, before preparing and handling medications, and before and after applying and removing gloves.</p> <p>2. Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including acute on chronic combined systolic and diastolic congestive heart failure (CHF), type two diabetes mellitus, cellulitis of the right lower limb, chronic deep vein thrombosis right lower extremity, lymphedema, primary hypertension, and hypothyroidism.</p> <p>Review of the physician orders revealed an order dated 11/08/24 at 2:28 A.M. for contact isolation for clostridium difficile (c. diff) (a bacterium that can cause diarrhea and other intestinal conditions), that was discontinued on 11/08/24. Another order, dated 11/08/24 and timed 2:28 A.M., was for enhanced barrier precautions (EBP) every shift for a leg wound. There were no orders in any status (active, discontinued, complete, pending signature, or struck out) for droplet isolation.</p> <p>Observation on 11/12/24 from 8:44 A.M. to 8:56 A.M. revealed LPN #331 completed medication administration for Resident #21 and exited Resident #21's room without performing hand hygiene. During the observation, LPN #331 proceeded to prepare medications for administration to Resident #44, grabbed two pairs of gloves, entered the room of Resident #44 (whose door had a personal protective equipment [PPE] organizer and a sign indicating he was in droplet isolation) with no hand hygiene, no mask, and gloves in her hand. Observation from the doorway revealed LPN #331 administered Resident #44 his oral medications, donned gloves, administered eye drops into each eye, removed and discarded the gloves, donned a clean pair of gloves without performing hand hygiene in-between glove changes, and administered Resident #44 his insulin before discarding the gloves and washing her hands.</p> <p>Interview on 11/12/24 at 9:00 A.M. with LPN #331 confirmed she had not performed hand hygiene between administering medications to Resident #21 and Resident #44 and hand hygiene should be performed between providing medications to each resident. LPN #331 further confirmed the sign on Resident #44's door indicated he was in droplet isolation but should not have been in droplet isolation. During the interview, LPN #331 stated Resident #44 was being checked for c. diff, while in the hospital, but his result was negative. LPN #331 confirmed droplet isolation was not the correct form of transmission-based precautions for c. diff but added that he was no longer in isolation and was uncertain as to whether he was in EBP or not.</p> <p>Review of the facility policy titled Medication Administration, last revised 06/18/24, revealed staff were to wash their hands prior to medication administration per facility protocol</p> <p>Review of the facility policy titled Hand Hygiene, dated June 2023, revealed staff were to perform hand hygiene between resident contacts, before preparing and handling medications, and before and after applying and removing gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Transmission-Based Precautions, revised 06/09/19, revealed the form of isolation should be the least restricted possible, and droplet precautions were indicated when there was a risk of transmission of pathogens through close respiratory or mucous membrane contact with respiratory secretions and staff were to wear a mask when droplet precautions are in place.</p> <p>This deficiency is an incidental finding identified during the complaint investigation.</p>		