

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: 365580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
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)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of facility policy, the facility failed to implement an effective pressure ulcer prevention program to promote healing and to ensure Resident #51, who was cognitively impaired, dependent on staff for hygiene and had functional limitation to bilateral upper extremities, received interventions to prevent skin breakdown, timely assessments to her right third and fourth finger wounds and wound care as ordered by the physician. Actual Harm occurred on 10/08/25 when Resident #51 was assessed by Nurse Practitioner (NP) #301 and found to have long nails on her right hand digging into her hand causing wounds (no size or wound type provided in documentation). On 10/09/25 Licensed Practical Nurse (LPN) #205 attempted to assess and cleanse Resident #51's right hand, however, the resident refused. LPN #205 stated she would again approach the resident after lunch, however, there was no evidence that Resident #51's right hand was assessed. There were no further nurse progress notes or wound assessments completed between 10/10/25 and 10/30/25. On 10/31/25 NP #301 assessed the hand wounds (no size or wound type provided in documentation) as infected and ordered an oral antibiotic treatment. Resident #51 was not seen by Wound NP #201 for the hand wounds to be comprehensively assessed until 11/10/25 at which time Wound NP #201 noted Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcers to the right third and fourth fingers. This affected one (Resident #51) of five residents reviewed for pressure ulcers. The facility census was 49. Findings include: Review of the medical record for Resident #51 revealed an admission date of 02/21/23 with diagnoses including diabetes mellitus, congestive heart failure, peripheral vascular disease and contracted hands. The resident's most recent hospitalization was on 05/29/25. Review of Resident #51's care plan dated 05/21/24 revealed the resident had limited physical mobility related to contractures and weakness. Staff were to monitor, document and report as needed any signs or symptoms of immobility, contractures forming or worsening, thrombus formation, skin breakdown and fall related injury. Review of Resident #51's care plan dated 08/08/25 revealed the resident was at risk for pressure ulcers related to a history of ulcers, inability to position herself, incontinence and poor skin integrity. Staff were to assess and monitor for any skin breakdown and report to the physician and inspect skin for irregularities daily during care and report abnormal findings to the nurse or physician. Review of the occupational therapy Discharge summary dated [DATE] revealed therapy staff had recommended Resident #51 have a restorative nursing program to bilateral upper extremities with stretching and a carot orthotic to her right hand which was to be placed in the hand during morning care and removed with nighttime care. Review of Resident #51's Braden assessment dated [DATE] revealed she was at moderate risk for skin breakdown. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 had impaired cognition, had not rejected care during the review, was dependent on staff for showering, personal hygiene and transfers, and had functional limitation in range of motion to the upper extremity on both sides. Resident #51 had no pressure ulcers identified on this assessment. Review of the progress note dated 10/08/25 by NP #301 revealed she assessed Resident #51 and noted her nails were long and dirty and needed cut as they were digging into her (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 0686 Level of Harm - Actual harm Residents Affected - Few	hands and causing wounds (no description of the wounds was in the note). The resident's fingers were edematous and contracted. Resident #51 had a rolled washcloth in one hand but needed one in her other hand. She was noted to have contracted hands and NP #301 ordered staff to place rolled washcloths in each hand and to provide nail care as she was causing wounds to her hands. Review of the nursing progress note dated 10/09/25 at 11:39 A.M. by LPN #205 revealed Resident #51's husband was voicing concerns over the edema to the resident's right hand. LPN #205 noted moderate edema. Resident #51 began screaming loudly ouch during her assessment. LPN #205 reviewed the note dated 10/08/25 by NP #301 and verified the Resident #51's hand was swollen and her nails were very long and dirty and causing wounds. LPN #205 updated the husband and asked the resident if she could trim her nails who stated no. Review of the nursing progress note dated 10/09/25 at 11:54 A.M. revealed LPN #205 updated Resident #51's husband about NP #301's progress note and offered to soak the resident's hand and trim her nails after lunch. Resident repeatedly yelled and did not give consent. The husband was updated by the nurse that she would ask again after lunch. There was no evidence LPN #205 asked Resident #51 to soak her hand or trim her nails after lunch. Further review of the medical record revealed no additional nursing progress notes or wound assessments on Resident #51's hand wounds between 10/10/25 and 10/30/25. There was a wound assessment dated [DATE] by Wound NP #201, however, Wound NP #201 assessed an arterial foot ulcer at this visit and had not assessed Resident #51's right hand third and fourth fingers during her visit. Review of the progress note dated 10/31/25 at 4:20 P.M. by NP #301 revealed she assessed Resident #51's hands. She noted it had been previously mentioned Resident #51 needed nail care. NP #301 stated her nails were currently cutting into her hands due to the length and contractures. NP #301 clipped her nails and placed rolled washcloths in her hands. She spoke to therapy about possibly ordering splints with finger separators. NP #301 stated there were some wounds to her hands. She ordered an antibiotic for the infection. Review of the Medication Administration Record (MAR) for October 2025 for Resident #51 revealed an order for Doxycycline Hyclate (antibiotic) 100 milligrams (mg) two times a day for seven days dated 10/31/25. Review of physician's orders for Resident #51 revealed treatment orders to her right hand middle and ring finger (third and fourth fingers) were initiated on 11/05/25. Resident #51's order for carrot splints to bilateral hands were not implemented until 11/07/25. Review of the wound assessment dated [DATE] by LPN #302, who was also the facility's skin nurse, revealed Resident #51 had an unstageable (full-thickness tissue loss with the base of the ulcer covered by slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) in the wound bed) pressure ulcer to her right second and third fingers (documentation error as it should be third and fourth fingers) and these were first noted on 11/03/25 during NP #301's visit. The right second (third) finger was noted to be 1.5 centimeters in length by 1.5 centimeters in width. The depth was not able to be determined due to slough in the wound. Resident #51's fingernail was noted to be off. There was foul odor and an infection was suspected. Her hand was red, warm and edematous. The right middle (fourth finger) was noted to measure one centimeter in length by 1.5 centimeters in width. The depth was not able to be determined due to slough in the wound. Review of the nursing progress note dated 11/06/25 by LPN #302 revealed there were new areas noted on Resident #51's right hand to the middle (third) and fourth fingers. LPN #302 stated NP #301 was with her when the new areas were observed on 10/31/25. She stated the middle finger nail was coming off and hanging by skin which was removed. Wound NP #201 provided an order to apply Betadine, let dry and cover with alginate silver (wound treatment with antimicrobial), and place carrot splint wrapped with abdominal (ABD) pad inside the hand with a two by two gauze between fingers daily and as needed. The carrot splint was to be maintained in her hands and only be removed for hand hygiene and skin inspection. Review of the Treatment Administration Record (TAR) for November 2025 and December 2025 for the treatment order dated 11/07/25 to cleanse the middle and ring finger of the right hand with normal saline, apply Betadine, let dry and cover with alginate silver, place gauze pads between fingers and cover with pad, revealed Resident #51 did not have the treatments performed on 11/16/25, 11/19/25, (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/20/25, 11/25/25, 11/28/25, 11/30/25, 12/02/25, 12/08/25, 12/09/25 or 12/15/25. There was no indication in the nursing progress notes or TAR that Resident #51 refused these treatments. Review of the wound assessment dated [DATE] by Wound NP #201 revealed she saw Resident #51's second and third fingers (documentation error as it should be third and fourth fingers) as they were newly developed. NP #201 documented them as Stage III pressure ulcers. There were no measurements on this assessment. Wound NP #201 stated therapy was placing a carrot splint into Resident #51's hands to help with contractures. Review of Resident #51's care plan dated 12/15/25 revealed she had Stage III pressure ulcers to her right hand middle and third fingers (documentation error as it should be third and fourth fingers) related to immobility and contractures. Staff were to administer treatments as ordered and maintain the carrot splint in her right hand at all times and only be removed for hygiene and skin inspection and treatment. Observation on 12/15/25 at 9:24 A.M. of Resident #51 revealed she had a palm splint in her left hand. However, there was no carrot splint in her right hand or treatment. Observation on 12/15/25 at 1:27 P.M. of Resident #51 with LPN #302 revealed Resident #51 did not have her carrot splint in her right hand. LPN #302 verified it was not in place. She stated when it comes out of her hand, nursing staff had a difficult time placing back in her hand. The carrot splint was noted on the dresser beside the resident's bed. She stated Wound NP #201 was not measuring Resident #51's right third and fourth finger Stage III pressure ulcers as she does this weekly. Interview on 12/15/25 at 2:04 P.M. with LPN #302 revealed she first documented Resident #51's pressure ulcers to her right hand third and fourth fingers on 11/05/25 as that was the day she measured all wounds in house. She stated she measures wounds weekly. She stated she had documented unstageable for Resident #51's right third and fourth fingers as she could not see clearly and was unsure of the actual stage. Interview on 12/16/25 at 10:23 A.M. with LPN #302 verified Resident #51's Stage III pressure ulcers were to her third and fourth fingers. She stated the site of the pressure ulcers had been documented incorrectly on the wound assessment by herself on 11/05/25 and 11/06/25, by the Wound NP #201 on 11/10/25 and Resident #51's care plan dated 12/15/25. LPN #302 also verified the care plan for Resident #51's right hand third and fourth Stage III pressure ulcers was initiated on 12/15/25 after the survey was initiated. Interview on 12/16/25 at 2:05 P.M. with Wound NP #201 verified Resident #51's right third and fourth fingers were acquired at the facility and were first observed as Stage III pressure ulcers on 11/10/25. She was unable to state if Resident #51 had her splints in her hands during her visits. Interview on 12/16/25 at 2:19 P.M. with Therapy Manager #303 verified occupational therapy provided a splint order on 08/22/25 with a carrot splint to Resident #51's right hand. She stated therapy gave nursing documentation and then nursing was to place the restorative order in the computer. Interview on 12/17/25 at 9:28 A.M. with NP #301 revealed she first observed Resident #51's hand on 10/08/25 and noted her nails were very long and needed cut as they were digging into her hand and causing wounds. She stated she updated the nurse on duty that day. She stated the next visit on 10/31/25 she again saw Resident #51 with very long nails that needed cutting as they were digging into her hand causing wounds. She stated she assisted in cutting her nails and started her on an antibiotic because the wounds looked infected. NP #301 stated she did not think that on 10/08/25 it was a Stage III pressure ulcer as the skin was broken but not very deep. She verified the wounds had worsened due to her nails not getting trimmed and treatments not being put into place. She also verified the Stage III pressure ulcers to her right hand third and fourth fingers could have been prevented if the splint had been in place. NP #301 stated she does not see the wounds at the facility as Wound NP #201 follows with those weekly. Interview on 12/17/25 at 11:55 A.M. with the Director of Nursing (DON) verified Resident #51's treatments were not completed as ordered for her right hand third and fourth fingers on 11/16/25, 11/19/25, 11/20/25, 11/25/25, 11/28/25, 11/30/25, 12/02/25, 12/08/25, 12/09/25 and 12/15/25. Observation on 12/17/25 at 1:43 P.M. of Resident #51 with LPN #302 revealed her carrot splint was not in her right hand. LPN #302 stated it was in place prior to lunch, but when the aides assisted her to bed it probably came out and they never replaced it. Observation of wound care was performed with LPN #302. LPN #302 stated it (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	was hard to measure due to the area of the pressure ulcers and residents' contractures. She stated she continued with the same measurements weekly as it looked the same. She also stated she was unaware of Resident #51's wound to her right hand third and fourth fingers until 10/31/25. She stated LPN #205 did not update the physician or herself related to the skin breakdown to her fingers. Review of the facility policy titled, Pressure Ulcer Prevention, dated 09/01/13, stated it was the facility's policy to promote healthy intact skin and to identify and evaluate all residents at risk. Staff would observe the skin daily, and the plan would be to reduce or eliminate pressure to prevent skin breakdown. Review of the facility policy titled, Pressure Ulcer Treatment, dated 10/01/13, stated it was the facility's policy to provide guidelines for the treatment of pressure ulcers to facilitate healing. Staff were to perform an assessment upon development of a new wound and at least weekly thereafter, assess for mobility and assess for factors that would impair wound healing.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review the facility did not ensure medications were not stored expired and were stored securely in medication storage areas. This affected four of four medication carts observed and had the potential to affect all residents in the facility. The facility census was 49. Findings include: 1. An observation on [DATE] at 10:00 A.M. of the 300 Hall medication cart revealed the following: an opened bottle of Geri-Care acetaminophen (a non-narcotic pain medication) 1000 milligram (mg) tablets with an expiration date of 11/2025, two packets of Medline 0.9 ounce (oz) lubricating jelly with an expiration date of 08/2022, two packets of Medline 0.9 oz lubricating jelly with an expiration date of [DATE], a packet of Medline 0.9oz lubricating jelly with an expiration date of [DATE], two Medline povidone iodine (a topical skin antiseptic) 10% swab sticks with an expiration date of 10/2024, a Medline povidone iodine 10% with an expiration date of 02/2025, a Medline povidone iodine 10% swab stick with an expiration date of 04/2025, and a PDI povidone iodine 10% swab stick with an expiration date of 08/2025, four PDI povidone iodine 10% swab sticks with an expiration date of 10/2025. An interview on [DATE] at 10:12 A.M. with Licensed Practical Nurse (LPN) #210 verified the above findings. A review of the facility policy titled Storage of Medications, dated [DATE] revealed the purpose of the policy is to ensure medications are stored in a safe and secure manner, outdated medications are not available for use, and outdated medications are destroyed. 2. On [DATE] at 5:57 A.M., an observation revealed three medication carts were sitting unlocked in the hallway by the nurses station near room [ROOM NUMBER]. The medication carts were labeled for resident rooms 115 to 130, 101 to 111, and 131 to 205. Licensed Practical Nurse (LPN) #202 was observed seated in a small office area behind nurses station, out of sight of the two carts labeled 101 to 111 and 131 to 205. On [DATE] at 6:00 A.M., an interview with LPN #202 verified the three medication carts were unlocked. LPN #202 stated there was no reason the medication carts were unlocked because she had already finished her medication pass so the carts should have been locked. Review of the facility's policy titled Storage of Medications, dated [DATE], revealed medications would be stored in a safe and secure manner. 3. An observation on [DATE] at 11:41 A.M. of the intravenous (IV) treatment cart revealed four Medefil prefilled heparin (a blood thinner used to help prevent IV blood clots from forming at the ends of an IV catheter inside the body) flush syringes 100 units per 5 ml with an expiration date of 11/2025. An interview on [DATE] at 11:45 A.M. with the Assistant Director of Nursing (ADON) verified the above findings. A review of the facility policy titled Storage of Medications, dated [DATE] revealed the purpose of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the policy was to ensure medications are stored in a safe and secure manner, deteriorated or outdated medications are not available for use, and outdated or deteriorated medications are destroyed.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. Based on record review, interview, and review of the Long-Term Care Resident Assessment Instrument (LTC RAI) 3.0 User's Manual, the facility failed to complete non-comprehensive Minimum Data Set (MDS) assessments in a timely manner. This affected four residents (#2, #8, #25, and #26) out of four residents reviewed for non-comprehensive resident assessments. The facility census was 49. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 11/03/20 with diagnoses including cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, hypertension, altered mental status, and dysphagia. On 12/16/25 at 11:28 A.M., review of the quarterly MDS assessment with an Assessment Reference Date (ARD) of 11/28/25 revealed it had not yet been completed. Sections A, B, C, GG, I, J, L, N, O, and S had not been completed. On 12/16/25 at 12:23 P.M., an interview with Regional MDS Nurse #204 verified Resident #2's quarterly MDS assessment had an ARD date of 11/28/25 and it had not yet been completed. On 12/16/25 at 12:30 P.M., an interview with MDS Nurse #154 stated she was the only MDS nurse for the facility and she sometimes had to wait on other departments to complete their sections of the MDS assessments. Review of the LTC RAI 3.0 User's Manual, revised October 2025, revealed quarterly assessments' ARD dates were no later than 92 calendar days after the previous Omnibus Budget Reconciliation Act of 1987 (OBRA) assessment date and the MDS completion date was no later than 14 days after the ARD date. Further review of Resident #2's quarterly MDS assessment with an ARD date of 11/28/25 and the guidelines set forth in the LTC RAI 3.0 User's Manual indicated Resident #2's quarterly MDS assessment was four days beyond the required completion date. 2. Review of the medical record for Resident #8 revealed an admission date of 06/06/22 and re-admission date of 11/01/23. Diagnoses included chronic pancreatitis, type two diabetes mellitus, major depressive disorder, cerebral infarction, and hypertension. On 12/16/25 at 11:52 A.M., review of the quarterly MDS assessment with an ARD of 11/21/25 revealed it had not yet been completed. Sections A, B, C, GG, I, J, L, N, O, and S had not been completed. On 12/16/25 at 12:23 P.M., an interview with Regional MDS Nurse #204 verified Resident #8's quarterly MDS assessment had an ARD date of 11/21/25 and it had not yet been completed. On 12/16/25 at 12:30 P.M., an interview with MDS Nurse #154 stated she was the only MDS nurse for the facility and she sometimes had to wait on other departments to complete their sections of the MDS assessments. Review of the LTC RAI 3.0 User's Manual, revised October 2025, revealed quarterly assessments' ARD dates were no later than 92 calendar days after the previous OBRA assessment date and the MDS completion date was no later than 14 days after the ARD date. Further review of Resident #8's quarterly MDS assessment with an ARD date of 11/21/25 and the guidelines set forth in the LTC RAI 3.0 User's Manual indicated Resident #8's quarterly MDS assessment was 11 days beyond the required completion date. 3. Review of the medical record for Resident #25 revealed an admission date of 05/26/22 with diagnoses including cerebral infarction, dysphagia, moderate protein-calorie malnutrition, and dementia. On 12/16/25 at 9:50 A.M., review of the quarterly MDS assessment with an ARD of 11/21/25 revealed it had not yet been completed. Sections A, B, C, GG, I, J, L, N, O, and S had not been completed. On 12/16/25 at 12:23 P.M., an interview with Regional MDS Nurse #204 verified Resident #25's quarterly MDS assessment had an ARD date of 11/21/25 and it had not yet been completed. On 12/16/25 at 12:30 P.M., an interview with MDS Nurse #154 stated she was the only MDS nurse for the facility and she sometimes had to wait on other departments to complete their sections of the MDS assessments. Review of the LTC RAI 3.0 User's Manual, revised October 2025, revealed quarterly assessments' ARD dates were no later than 92 calendar days after the previous OBRA assessment date and the MDS completion date was no later than 14 days after the ARD date. Further review of Resident #25's quarterly MDS assessment with an ARD date of 11/21/25 and the guidelines set forth in the LTC RAI 3.0 User's Manual indicated Resident #25's quarterly MDS assessment was 11 days beyond the required completion date. 4. Review of the medical record for (continued on next page)		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #26 revealed an admission date of 08/05/25 with diagnoses including type two diabetes mellitus, end stage renal disease, dependence on renal dialysis, and congestive heart failure. Resident #26 was discharged from the facility on 11/30/25. On 12/16/25 at 12:11 P.M., review of the discharge return anticipated MDS assessment with an ARD of 11/30/25 revealed it had not yet been completed. Sections A, B, C, GG, I, J, N, O, and S had not been completed. On 12/16/25 at 12:23 P.M., an interview with Regional MDS Nurse #204 verified Resident #26's discharge MDS assessment had an ARD date of 11/30/25 and it had not yet been completed. On 12/16/25 at 12:30 P.M., an interview with MDS Nurse #154 stated she was the only MDS nurse for the facility and she sometimes had to wait on other departments to complete their sections of the MDS assessments. Review of the LTC RAI 3.0 User's Manual, revised October 2025, revealed discharge return anticipated assessments had no ARD date requirements and the MDS completion date was no later than 14 days after discharge. Further review of Resident #26's discharge return anticipated MDS assessment with an ARD date of 11/30/25 and the guidelines set forth in the LTC RAI 3.0 User's Manual indicated Resident #26's discharge MDS assessment was two days beyond the required completion date.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of facility policy, the facility failed to ensure accurate documentation in the medical records for Resident #4, #8, #47 and #51. This affected four residents (Residents #4, #8, #47 and #51) out of 25 residents reviewed for resident records. The facility census was 49. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 02/21/23 with diagnoses including diabetes mellitus, congestive heart failure, peripheral vascular disease and contracted hands. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 had impaired cognition. Review of the wound assessment dated [DATE] by Licensed Practical Nurse (LPN) #302, who was also the facility's skin nurse, revealed Resident #51 had an Unstageable Pressure Ulcer (full-thickness tissue loss with the base of the ulcer covered by slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) in the wound bed) to her right second and third fingers (documentation error as it should be third and fourth fingers) and these were first noted on 11/03/25 during NP #301's visit. The right second (third) finger was noted to be 1.5 centimeters in length by 1.5 centimeters in width. The depth was not able to be determined due to slough in the wound. Resident #51's fingernail was noted to be off. There was foul odor and an infection was suspected. Her hand was red, warm and edematous. The right middle (fourth finger) was noted to measure 1 centimeter in length by 1.5 centimeters in width. The depth was not able to be determined due to slough in the wound. Review of the wound assessment dated [DATE] by Wound Nurse Practitioner (NP) #201 revealed she saw Resident #51's second and third fingers (documentation error as it should be third and fourth fingers) as they were newly developed. NP #201 documented them as Stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcers. Review of Resident #51's care plan dated 12/15/25 revealed she had Stage III pressure ulcers to her right hand middle and third fingers (documentation error as it should be third and fourth fingers) related to immobility and contractures. Interview on 12/16/25 at 10:23 A.M. with LPN #302 verified Resident #51's Stage III pressure ulcers are to her third and fourth fingers. She stated the site of the pressure ulcers had been documented incorrectly on the wound assessment by herself on 11/05/25, by the Wound NP #201 on 11/10/25 and Resident #51's care plan dated 12/15/25. Observation on 12/17/25 at 1:43 P.M. of Resident #51 with LPN #302 revealed her Stage III pressure ulcers were to her right third and fourth fingers. Review of the facility policy titled, Charting and Documentation, undated, stated all observations, medications administered, and services performed must be documented in the resident's clinical record. 2. Review of the medical record for Resident #4 revealed an admission date of 04/03/24 with (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley-Boardman		STREET ADDRESS, CITY, STATE, ZIP CODE 7148 West Blvd Youngstown, OH 44512	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses including hypertension, altered mental status and anxiety. Resident #4 was discharged to the hospital on [DATE] and did not return to the facility until 08/02/25. Review of the weekly skin assessments dated from 08/14/25 through 12/10/25 for Resident #4 ' s left heel unstageable (full-thickness tissue loss with the base of the ulcer covered by slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) in the wound bed) pressure ulcer revealed the date the wound was acquired was on 07/30/25 at the facility. Interview on 12/22/25 at 9:50 A.M. with Licensed Practical Nurse (LPN) #302 verified Resident #4 was not in the facility on 07/30/25 for the assessment. She stated the documentation was inaccurate on his weekly skin assessments of his left heel unstageable pressure ulcer dated from 08/14/25 through 12/10/25. She stated he was readmitted to the facility on [DATE] and his initial assessment for the left heel pressure ulcer was on that date. Review of the facility policy titled, Charting and Documentation, undated, stated all observations, medications administered, and services performed must be documented in the resident ' s clinical record. 3. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including left arm fracture, history of falling, diabetes mellitus type II, malnutrition, heart failure, and dysphagia (difficulty swallowing). Review of the Brief Interview for Mental Status (BIMS), a tool to measure cognition, dated 12/08/25 revealed Resident #47 was cognitively intact. Review of the Activities of Daily Living (ADL) assessment dated [DATE] revealed Resident #47 required one person assistance to transfer, toilet, walk, and dress. Review of the physician orders revealed an order dated 12/01/25 to check vital signs daily every dayshift to start on 12/04/25 and an order dated 12/01/25 to weigh daily and update the physician if there was a gain of three pounds in twenty-four hours or five pounds in one week and document to start on 12/04/25. Review of the care plan dated 12/03/25 revealed Resident #47 had potential for fluid deficit with interventions to monitor vital signs as ordered and monitor for signs or symptoms of dehydration such as weight loss; the resident had a nutritional problem related to heart failure and the use of a feeding tube with an intervention to monitor and report to the physician signs or symptoms of malnutrition such as significant weight loss of three pounds in one week, greater than five percent in one month, or greater than seven and a half percent in three months. Review of the Treatment Administration Record (TAR) from 12/01/25 to 12/23/25 revealed the absence of documented vital signs on 12/04/25, 12/08/25, 12/16/25, and 12/18/25. Review of the TAR from 12/01/25 to 12/23/25 revealed the absence of documented weights on 12/04/25, 12/08/25, 12/10/25, 12/12/25, 12/13/25, 12/16/25, 12/18/25, 12/19/25, and 12/21/25. An interview on 12/22/25 at 12:35 P.M. with the Assistant Director of Nursing (ADON) verified the absence of documented vital signs and weights. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled Charting and Documentation, revealed all services provided to the resident were to be documented in the medical record, changes in condition were to be recorded, and was to include if the physician was notified. 4. Review of the medical record for Resident #8 revealed an admission date of 06/06/22 and re-admission date of 11/01/23. Diagnoses included chronic pancreatitis, type two diabetes mellitus, major depressive disorder, cerebral infarction, and hypertension. Review of Resident #8's activities participation documentation for the previous 30 days revealed there was no documentation of any activities offered to Resident #8 on 11/28/25, 11/30/25, 12/03/25, and 12/12/25. On 12/17/25 at 4:45 P.M., an interview with Activities Assistant #122 verified there was no documentation for any activities for Resident #8 on 11/28/25, 11/30/25, 12/03/25, and 12/12/25. On 12/18/25 at 11:21 A.M., an interview with Activities Assistant #122 stated he spoke with Activities Assistant #108, who worked on the days with no documentation, and she reported she forgot to document activities provided those days. Activities Assistant #122 said he had no way of knowing who participated in the activities held on those days because he did not lead those activities, claiming Activities Assistant #108 led the activities those days. Review of the undated facility policy titled Charting and Documentation, revealed all services provided to the resident were to be documented in the medical record.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of facility policy, the facility failed to honor Resident #13's rights regarding choosing when to get out of bed. This affected one resident (#13) out of five residents reviewed for activities of daily living (ADL). The facility census was 49. Findings include: Review of the medical record for Resident #13 revealed an admission date of 12/26/24 with diagnoses including dementia, repeated falls, muscle weakness, hypertension, glaucoma, age-related osteoporosis, and personal history of transient ischemic attack (stroke). Review of the care plan revised 01/13/25 indicated Resident #13 had impaired self-performance abilities for ADL due to repeated falls, weakness, and osteoporosis. Interventions included transfer assistance of two staff (effective 01/13/25). Review of the physician's orders for Resident #13 identified an order for transfer assistance of one staff with rails (effective 07/02/25). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had moderately impaired cognition and required substantial or maximal assistance for rolling left and right, sitting to lying, lying to sitting, sit to stand, and chair- or bed-to-chair transfer. On 12/15/25 at 3:00 P.M., an observation of Resident #13's room revealed Housekeeper #300 responded to Resident #13 verbally calling out for assistance. Resident #13 expressed wanting to get out of bed at that time. Housekeeper #300 assisted Resident #13 with turning the call light on. In less than one minute, an unnamed nurse aide went into Resident #13's room and turned the call light off, exiting the room without providing assistance. On 12/15/25 at 3:03 P.M., an observation revealed Housekeeper #300 came out of the room adjacent to Resident #13's room and looked at Resident #13's room. Housekeeper #300 stated at this time that someone turned the call light off without getting Resident #13 out of bed. Housekeeper #300 turned Resident #13's call light back on at this time. On 12/15/25 at 3:08 P.M., an observation revealed Regional Director of Nursing (DON) entered Resident #13's room to answer the call light, and Resident #13 asked to get up. Regional DON turned the call light off and exited the room. Regional DON informed a nurse aide that Resident #13 wanted to get out of bed. On 12/15/25 at 3:11 P.M., Certified Nursing Assistant (CNA) #113 brought a mechanical lift device to Resident #13's room and then informed Resident #13 they could not provide assistance until the floors were dry since housekeeping had mopped. On 12/15/25 at 3:12 P.M., an interview with Housekeeper #300 verified staff turned Resident #13's call light off without providing assistance. Housekeeper #300 said nursing aides frequently went into rooms and turned call lights off without providing assistance. On 12/23/25 at 8:25 A.M., an interview with Regional Staff Educator #208 said if staff were in the middle of something, it was ok to turn the call light off, finish up what they were doing, and then return to address the resident's needs. Regional Staff Educator #208 further stated the expectation was that staff did not just turn the call light off and walk away without going back. Review of the facility policy titled Answering the Call Light, dated 04/07/16, revealed staff would respond to resident requests and needs in a timely manner. The policy indicated staff were to turn the call light off before asking the resident what they needed assistance with.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure call lights were within reach for Resident #44 and Resident #30. This affected two residents (#44 and #30) out of two residents reviewed for call lights. The facility census was 49. Findings include: 1. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnosis including stroke, respiratory failure, dysphagia (difficulty swallowing), aphasia (a language disorder due to brain damage), hemiplegia (one-sided paralysis or weakness), hemiparesis (paralysis on one side of the body), and malnutrition. Review of the care plan dated 07/03/25 revealed Resident #44 was at risk for falls with an intervention to keep the call light within reach. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 was moderately cognitive impaired, had upper limb impairment on one side, required maximal assistance or was completely dependent on staff for care needs, did not reject care, and was always incontinent of bowel and bladder. An observation on 12/15/25 at 10:43 A.M. revealed the call light was under Resident #44's pillow at head height on the right-hand side. An observation on 12/17/25 at 9:31 A.M. revealed the call light was on the right-hand side at head level and when asked, Resident #44 was unable to reach the call light. An interview on 12/17/25 at 9:54 A.M. with Licensed Practical Nurse (LPN) #210 verified Resident #44 was unable to reach the call light. 2. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including sacral fracture, repeated falls, dependence on renal dialysis, heart failure, spinal stenosis, and weakness. Review of the care plan dated 05/30/25 revealed Resident #30 was at risk for falls with interventions to keep needed items in reach, remind to ask for assistance before standing or walking, provide visual reminders to use call light; and keep the call light within reach. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #30 had fractures and other trauma, was cognitively intact, was dependent on facility staff for toileting, required moderate assistance for transfers, was frequently incontinent of bowel and bladder, required hemodialysis, and did not reject care. An observation on 12/22/25 at 12:16 P.M. revealed facility staff leaving the room after serving a lunch tray. Resident #30 was in the wheelchair, had a tray table positioned over her, and had a lunch tray on the tray table ready to eat lunch. The call light was attached to the bed and not on Resident #30's person. When asked if she could locate the call light, the resident was unable to find its location. An interview on 12/22/25 at 12:26 P.M. with the Assistant Director of Nursing (ADON) verified the call light was not within reach.		

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Based on record review, interview, review of the resident handbook and facility policy review, the facility failed to honor visitors per the preference of Resident #63. This affected one resident (#63) of one resident reviewed for visitation. The facility census was 49. Findings include: Review of the medical record for Resident #63 revealed an admission date of 08/07/25 with diagnoses including sepsis, chronic kidney disease and malignant neoplasm (cancer) of the prostate. Review of the nursing progress note dated 09/30/25 at 3:54 P.M. for Resident #63 revealed a plan of care meeting was held with the resident and his son. The facility offered hospice care and discussed Resident #63's decline in status. Review of the text message dated 10/26/25 at 8:31 A.M. sent from Licensed Practical Nurse (LPN) #207 to Regional Staff Educator #208. LPN #207 stated she was instructed by the facility's staff aide that family were not permitted to spend the night in the building. She stated she was updating her as Resident #63's son had spent the previous night (10/25/25 into 10/26/25) with his father. LPN #207 also stated Resident #63's son was upset with her because the resident was refusing medications. LPN #207 stated the son had asked her to demand Resident #63 take his medication rather than ask the resident to take his medication. LPN #207 stated to Resident #63's son she was unwilling to violate his rights if he refused them. Review of the nursing progress note dated 10/26/25 at 11:21 P.M. for Resident #63 revealed his family was at the bedside. LPN #207 informed all family members of visiting hours and that they would need to come back to the facility in the morning as visiting hours had ended. The family member at the bedside stated he wasn't leaving. The nurse then explained to him that wasn't how the facility hours worked. Resident #63's family member then stated he was not going to argue with the nurse. LPN #207 called the police to come to the facility to have him leave. LPN #207 stated the visiting hours were from 8:30 A.M. to 8:00 P.M. The police officers informed Resident #63's family member he would need to leave, or he would be charged with trespassing. The family member left the facility. Review of a statement, undated, by Regional Staff Educator #208 revealed LPN #207 had updated her on 10/26/25 related to Resident #63's son being in the facility past visiting hours and demanding she force Resident #63 to take his medication. LPN #207 stated the family was educated on his rights regarding taking medications. There was no further discussion of the facility's visiting hours. Interview on 12/22/25 at 11:25 A.M. with the Administrator revealed LPN #207 stated to her that Resident #63's son was a very big man and was intimidating. She stated LPN #207 asked him to leave and felt that she needed to call the police as no management was in the building. The Administrator stated she was a nurse with the agency company, so she was unaware of their visiting hours. The Administrator verified the nurse had not documented any safety concerns for herself or other residents in the nursing progress notes or her text message sent to Regional Staff Educator #208. Interview on 12/22/25 at 12:58 P.M. with the Administrator verified there were no specific visiting hours. Interview on 12/22/25 at 3:06 P.M. with the Administrator verified the resident handbook stated there were no specific visiting hours listed. Interview on 12/23/25 at 3:17 P.M. with Resident #63's son revealed he had not argued or become confrontational with the nursing staff while he was visiting his father. He stated he lived out of state and was traveling back and forth from home to the facility and only wanted to be with his father to support him. Resident #63's son stated he was concerned as there was not consistent staff, and his father was unable to do anything for himself. He stated on the night of 10/26/25 he had taken his brother home around 10:30 P.M. and then went back to the facility. When he arrived, LPN #207 stated visiting hours were over and he had to leave. He attempted to explain he just wanted to be there for his dad. Resident #63's son stated police arrived and asked him to leave. He denied arguing with the nurse or causing concerns with safety at the facility. Review of the undated facility's Resident Handbook revealed family and friends were encouraged to visit. It also stated that while the entrance doors were locked at 8:00 P.M., visitors could enter the building by ringing the doorbell. There was no mention of specific visiting hours or family staying with the residents overnight. Review (continued on next page)		

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility policy titled, Visitation, dated 03/22/23, stated the facility permitted residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the facility investigation and facility policy review, the facility failed to report an allegation of misappropriation to the State Agency for Resident #17. This affected one resident (#17) of two residents reviewed for misappropriation. The facility census was 49. Findings include: Review of the medical record for Resident #17 revealed an admission date of [DATE] with diagnoses including fractures of the left tibia and fibula, multiple sclerosis, diabetes and dependence on renal dialysis. Resident #17 expired at the hospital on [DATE] at 10:07 A.M. Review of the physician's orders for [DATE] for Resident #17 revealed an order for Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 milligrams (mg), one tablet every six hours as needed for pain dated [DATE]. This order was discontinued on [DATE] at 3:14 P.M. Review of the Medication Administration Record (MAR) for [DATE] for Resident #17 revealed she had received her last dose of Hydrocodone-Acetaminophen 5-325 mg on [DATE] at 3:56 A.M. Review of the nursing progress notes for Resident #17 revealed on [DATE] at 6:40 A.M. she was sent to the hospital emergency room due to difficulty breathing. On [DATE] at 10:07 A.M., the facility was updated Resident #17 had expired upon arrival at the hospital. Review of the Controlled Drug Record for Resident #17 for her Hydrocodone-APAP 5/325 mg revealed a nurse had signed out one tablet on [DATE] at 11:19 P.M. The nurse's signature could not be recognized due to illegibility. Review of the facility investigation dated [DATE] by the Administrator revealed a concern was received from a nurse stating that while she was moving Resident #17's Hydrocodone-Acetaminophen to the discontinued drawer following her passing away, she noted there was a medication entry signed out after Resident #17 had passed away. The nurse noted the narcotic medication card matched the controlled drug record for the number of pills remaining. The Administrator updated the pharmacy, and an internal investigation was initiated. The two nurses who had worked the shift on [DATE] were suspended, interviewed and drug tested. The Administration and Director of Nursing (DON) performed an audit on all the narcotics and staff were educated. There was no evidence of narcotic misappropriation or diversion concluded from the investigation, and the facility determined it was a documentation error. Interview on [DATE] at 9:01 A.M. with the DON revealed the facility did an internal investigation for Resident #17's missing narcotic. He stated the facility did not find evidence of misappropriation. The DON stated the State Agency was not updated as it was an isolated incident. Interview on [DATE] at 9:18 A.M. with the Administrator verified she had not filed a self-reported incident (SRI) with the State Agency for Resident #17's missing narcotic. She stated she thought due to the resident no longer being at the facility she did not need to file. Review of the facility policy titled, Abuse Prohibition, dated [DATE], revealed misappropriation of resident property means the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy stated the facility would ensure that all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown course and misappropriation of resident property, are reported no later than 24 hours if the events that caused the allegation did not involve abuse or serious bodily injury to the administrator of the facility and other officials including to the State Survey Agency.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review, interview, and review of the Long-Term Care Resident Assessment Instrument (LTC RAI) 3.0 User's Manual, the facility failed to complete significant change Minimum Data Set (MDS) assessments in a timely manner for Residents #11 and #15. This affected two residents (#11 and #15) out of three residents reviewed for comprehensive resident assessments. The facility census was 49. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 03/08/20 with diagnoses including chronic obstructive pulmonary disease, bladder cancer, major depressive disorder, congestive heart failure, and atrial fibrillation. Resident #11 was admitted to hospice services on 11/06/25. On 12/16/25, review of the significant change MDS assessment with an Assessment Reference Date (ARD) of 11/14/25 revealed it had not yet been completed. Sections A, B, C, GG, I, J, L, N, O, S, and V had not been completed. On 12/16/25 at 12:23 P.M., an interview with Regional MDS Nurse #204 verified Resident #11's significant change MDS assessment had an ARD date of 11/14/25 and it had not yet been completed. On 12/16/25 at 12:30 P.M., an interview with MDS Nurse #154 stated she was the only MDS nurse for the facility and she sometimes had to wait on other departments to complete their sections of the MDS assessments. Review of the LTC RAI 3.0 User's Manual, revised October 2025, revealed significant change assessments' ARD dates were no later than the fourteenth calendar day after the significant change was determined to have occurred and the MDS completion date was no later than the fourteenth day after the significant change was determined to have occurred. Further review of Resident #11's significant change MDS assessment with an ARD date of 11/14/25 and the guidelines set forth in the LTC RAI 3.0 User's Manual indicated Resident #11's significant change MDS assessment was 32 days beyond the required completion date. 2. Review of the medical record for Resident #15 revealed an admission date of 09/11/25 with diagnoses including cerebral infarction, type two diabetes mellitus, major depressive disorder, atrial fibrillation, dementia, hypertension, and altered mental status. Resident #15 was admitted to hospice services on 11/12/25. On 12/16/25, review of the significant change MDS assessment with an ARD of 11/19/25 revealed it had not yet been completed. Sections A, B, C, GG, I, J, L, N, O, S, and V had not been completed. On 12/16/25 at 12:23 P.M., an interview with Regional MDS Nurse #204 verified Resident #15's significant change MDS assessment had an ARD date of 11/19/25 and it had not yet been completed. On 12/16/25 at 12:30 P.M., an interview with MDS Nurse #154 stated she was the only MDS nurse for the facility and she sometimes had to wait on other departments to complete their sections of the MDS assessments. Review of the LTC RAI 3.0 User's Manual, revised October 2025, revealed significant change assessments' ARD dates were no later than the fourteenth calendar day after the significant change was determined to have occurred and the MDS completion date was no later than the fourteenth day after the significant change was determined to have occurred. Further review of Resident #15's significant change MDS assessment with an ARD date of 11/19/25 and the guidelines set forth in the LTC RAI 3.0 User's Manual indicated Resident #15's significant change MDS assessment was 27 days beyond the required completion date.		

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident assessments were accurately completed. This affected two residents (#25 and #51) of 25 residents' assessments reviewed. The facility census was 49. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 02/21/23 with diagnoses including diabetes mellitus, congestive heart failure, chronic pain, peripheral vascular disease, hypertension and anxiety. Review of the physician's orders for Resident #51 revealed she had an order for Hydrocodone-Acetaminophen 5-325 milligrams (mg) every six hours as needed for pain dated 07/15/24. Review of the Medication Administration Record (MAR) for October 2025 for Resident #51 revealed she had received Hydrocodone-Acetaminophen 5-325 mg for pain on 10/01/25 at 1:00 A.M. and 8:50 P.M., on 10/03/25 at 8:53 A.M., on 10/04/25 at 1:40 P.M. and 8:44 P.M., and on 10/05/25 at 6:02 A.M. and 8:44 P.M. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 received scheduled pain medication but had not received as needed pain medication in the five days prior to 10/05/25. Interview on 12/17/25 at 11:55 A.M. with the Director of Nursing (DON) verified the MDS on 10/05/25 was inaccurate as she had received her as needed pain medication, Hydrocodone-Acetaminophen 5/325 mg, on 10/01/25, 10/03/25, 10/04/25 and 10/05/25.		

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 12/31/2025
NAME OF PROVIDER OR SUPPLIER Shepherd of the Valley-Boardman		STREET ADDRESS, CITY, STATE, ZIP CODE 7148 West Blvd Youngstown, OH 44512	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to timely update care plans to address changes in a resident's condition. This affected one resident (#51) of 25 resident care plans reviewed. The facility census was 49. Findings include: Review of the medical record for Resident #51 revealed an admission date of 02/21/23 with diagnoses including diabetes mellitus, congestive heart failure, peripheral vascular disease and contracted hands. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 had impaired cognition. Review of the wound assessment dated [DATE] by Licensed Practical Nurse (LPN) #302, who is also the facility's skin nurse, revealed Resident #51 had an unstageable pressure ulcer (full-thickness tissue loss with the base of the ulcer covered by slough (yellow, tan, gray, green or brown) or eschar (tan, brown or black) in the wound bed) to her right second and third fingers (documentation error as it should be third and fourth fingers) and these were first noted on 11/03/25 during Nurse Practitioner (NP) #301's visit. The right second (third) finger was noted to be 1.5 centimeters in length by 1.5 centimeters in width. The depth was not able to be determined due to slough in the wound. Resident #51's fingernail was noted to be off. There was foul odor and an infection was suspected. Her hand was red, warm and edematous. The right middle (fourth finger) was noted to measure 1 centimeter in length by 1.5 centimeters in width. The depth was not able to be determined due to slough in the wound. Review of the nursing progress note dated 11/06/25 by LPN #302 revealed there were new areas noted on Resident #51's right hand to the middle (third) and fourth fingers. LPN #302 stated NP #301 was with her when the new areas were observed on 10/31/25. She stated the middle fingernail was coming off and hanging by skin which was removed. The Wound NP #201 provided an order to apply Betadine (antiseptic), let dry and cover with alginate silver (wound treatment with antimicrobial), and place carrot splint wrapped with abdominal (ABD) pad inside the hand with a two by two gauze between fingers daily and as needed. The carrot splint was to be maintained in her hands and only be removed for hand hygiene and skin inspection. Review of the wound assessment dated [DATE] by Wound NP #201 revealed she saw Resident #51's second and third fingers (documentation error as it should be third and fourth fingers) as they were newly developed. NP #201 documented them as Stage III pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling). There were no measurements on this assessment. Wound NP #201 stated therapy was placing a carrot splint into Resident #51's hands to help with contractures. Review of Resident #51's care plan dated 12/15/25 revealed she had Stage III pressure ulcers to her right hand middle and third fingers (documentation error as it should be third and fourth fingers) related to immobility and contractures. Staff were to administer treatments as ordered and maintain the carrot splint in her right hand at all times and only be removed for hygiene and skin inspection and treatment. Interview on 12/16/25 at 10:23 A.M. with LPN #302 verified Resident #51's Stage III pressure ulcers were not care planned timely as the care plan was initiated on 12/15/25.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 record reviews, observations, interview and review of the facility policies, the facility failed to ensure Resident #44 received needed assistance with activities of daily living (ADL). This affected one resident (#44) out of five residents reviewed for ADL. The facility census was 49. Findings include: Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnosis including stroke, respiratory failure, dysphagia (difficulty swallowing), aphasia (a language disorder due to brain damage), hemiplegia (one-sided paralysis or weakness), hemiparesis (paralysis on one side of the body), and malnutrition. Review of the care plan revealed Resident #44 had a potential for alteration in skin integrity due to fragile skin dated 06/17/25 with an intervention to keep the resident's nails short and clean. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 was moderately cognitively impaired, had upper limb impairment on one side, was dependent on staff for toileting, bathing, and hygiene, did not reject care, and was always incontinent of bowel and bladder. Review of the electronic bathing documentation from 11/21/25 to 12/16/25 revealed Resident #44 was bathed on 12/12/25 and 12/16/25. An observation on 12/15/25 at 10:43 A.M. revealed a brown grime underneath the fingernails of Resident #44's right hand. An observation on 12/17/25 at 9:31 A.M. revealed a brown grime underneath the fingernails of Resident #44's right hand. An interview on 12/17/25 at 9:54 A.M. with Licensed Practical Nurse (LPN) #210 verified the brown grime underneath Resident #44's fingernails and noted it could be fecal matter. Review of the facility policy titled Activities of Daily Living (ADL), dated 08/09/24, revealed the purpose of the policy was to provide ADL care to maintain grooming and personal hygiene, residents were to receive assistance with hygiene which included bathing and grooming, and interventions were monitored and evaluated.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure Resident #51 splint was implemented and utilized as ordered and failed to ensure Resident #44 had a physician's order for the splint observed on his left arm. This affected two residents (#51 and #44) of two residents reviewed for splint usage. The facility census was 49. Findings include: 1. Review of the medical record for Resident #51 revealed an admission date of 02/21/23 with diagnoses including diabetes mellitus, congestive heart failure, peripheral vascular disease and contracted hands. Review of Resident #51's care plan dated 05/21/24 revealed she had limited physical mobility related to contractures and weakness. Interventions included for staff to monitor, document and report as needed any signs or symptoms of immobility, contractures forming or worsening, thrombus formation, skin breakdown and fall related injury, referrals to physical therapy and occupational therapy as ordered and needed as well as a nursing range of motion program. Review of occupational therapy Discharge summary dated [DATE] revealed therapy staff had recommended Resident #51 have a restorative nursing program to bilateral upper extremities with stretching and a carrot orthotic to her right hand which was to be placed in the hand during morning care and removed with nighttime care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 had impaired cognition, had not rejected care during the review, was dependent on staff for showering, personal hygiene and transfers, and had functional limitation in range of motion to the upper extremity on both sides. Review of the progress note dated 10/08/25 by Nurse Practitioner (NP) #301 revealed she assessed Resident #51 and noted her nails were long and dirty and needed cut as they were digging into her hands and causing wounds. Her fingers were edematous and contracted. Resident #51 had a rolled washcloth in one hand but needed one in her other hand. She was noted to have contracted hands, and NP #301 ordered staff to place rolled washcloths in each hand and to provide nail care as she was causing wounds to her hands. Review of the progress note dated 10/31/25 at 4:20 P.M. by NP #301 revealed she assessed Resident #51's hands. She stated it had been previously mentioned Resident #51 needed nail care. NP #301 stated her nails were currently cutting into her hands due to the length and contractures. NP #301 clipped her nails and placed rolled washcloths in her hands. She spoke to therapy about possibly ordering splints with finger separators. NP #301 stated there were some wounds to her hands. She ordered an antibiotic for the infection. Review of physician's orders for Resident #51 revealed an order dated 11/07/25 for carrot splints to bilateral hands. There were no physician's orders between 08/22/25 through 11/06/25 for carrot splints to hands. Review of the nursing progress note dated 11/06/25 by Licensed Practical Nurse (LPN) #302 revealed there were new areas noted on Resident #51's right hand to the middle (third) and fourth fingers. LPN #302 stated NP #301 was with her when the new areas were observed on 10/31/25. She stated the middle fingernail was coming off and hanging by skin which was removed. Wound NP #201 (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided an order to apply Betadine (antiseptic), let dry and cover with alginate silver (wound treatment with antimicrobial), and place carrot splint wrapped with abdominal (ABD) pad inside the hand with a two by two gauze between fingers daily and as needed. The carrot splint was to be maintained in her hands and only be removed for hand hygiene and skin inspection. Review of Resident #51's care plan dated 12/15/25 revealed she had Stage III pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to her right hand middle and third fingers (documentation error as it should be third and fourth fingers) related to immobility and contractures. Staff were to administer treatments as ordered and maintain the carrot splint in her right hand at all times and only be removed for hygiene and skin inspection and treatment. Observation on 12/15/25 at 9:24 A.M. of Resident #51 revealed she had a palm splint in her left hand. However, there was no treatment or carrot splint in her right hand. Observation on 12/15/25 at 1:27 P.M. of Resident #51 with LPN #302 revealed Resident #51 did not have her carrot splint in her right hand. LPN #302 verified it was not in place. She stated when it comes out of her hand, nursing staff had a difficult time placing back in her hand. The carrot splint was noted on the dresser beside the resident's bed. Interview on 12/16/25 at 2:19 P.M. with Therapy Manager #303 verified occupational therapy provided a splint order on 08/22/25 with a carrot splint to Resident #51's right hand. She stated therapy gave nursing documentation and then nursing was to place the restorative and order in the computer. Interview on 12/17/25 at 9:28 A.M. with NP #301 revealed she first observed Resident #51's hand on 10/08/25 and noted her nails were very long and needed cut as they were digging into her hand and causing wounds. She stated she updated the nurse on duty that day. She stated the next visit on 10/31/25, she again saw Resident #51 with very long nails that needed cut as they were digging into her hand causing wounds. She stated she assisted in cutting her nails and started her on an antibiotic because the wounds looked infected. NP #301 stated she did not think that on 10/08/25 it was a Stage III pressure ulcer as the skin was broken but not very deep. She verified the wounds had worsened due to her nails not getting trimmed and treatments not being put into place. She also verified the Stage III pressure ulcers to her right hand third and fourth fingers could have been prevented if the splint had been in place. Observation on 12/17/25 at 1:43 P.M. of Resident #51 with LPN #302 revealed her carrot splint was not in her right hand. LPN #302 stated it was in place prior to lunch, but when the aides assisted her to bed it probably came out and they never replaced it. Review of the facility policy titled, Splints, dated 02/13/22, stated splints may be used when clinically indicated based on the resident's condition and functional needs. Staff applying the splints must have appropriate training or competency. 2. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnosis including stroke, respiratory failure, dysphagia (difficulty swallowing), aphasia (a language disorder due to brain damage), hemiplegia (one sided paralysis or weakness), hemiparesis (paralysis on one side of the body), and malnutrition. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS 3.0 assessment dated [DATE] revealed Resident #44 was moderately cognitively impaired, had upper limb impairment on one side, was dependent on staff for toileting, was dependent on staff for bathing, was dependent on staff for hygiene, did not reject care, and was always incontinent of bowel and bladder. Review of the current care plan revealed the care plan was absent for any interventions related to the application of a left arm splint. Review of the December 2025 physician orders revealed the absence of an order for left arm splinting. Review of the Treatment Administration Record (TAR) for 12/01/25 to 12/17/25 revealed the absence of any splint documentation. An observation on 12/17/25 at 9:31 A.M. revealed the presence of a splint applied to the left arm of Resident #44. An interview on 12/17/25 at 9:54 A.M. with LPN #210 verified there was a splint on the left arm of Resident #44. An interview on 12/18/25 at 9:22 A.M. with Therapy Manager #303 revealed Resident #44 wasn't in therapy, had a range of motion deficit in the left upper extremity, and if there was a schedule for the splint there would be a physician order for splint application. An interview on 12/18/25 at 3:17 P.M. with LPN #110 verified the absence of a physician order for the left arm splint. Review of the facility policy titled Splints, dated 02/13/22, revealed the following: splints were to be used when clinically indicated and were to follow clinical standards for necessity; documentation was to include the type of splint used and details of splint application; and the resident was to receive education on the purpose of the splint and the wear schedule.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, observation, interview and facility policy review, the facility failed to ensure a re-admission assessment and new fall prevention interventions were timely implemented after a four-day hospitalization post-fall with injury and failed to ensure fall prevention interventions were in place for Resident #30. This affected one resident (#30) out of one resident reviewed for accidents. The facility census was 49. Findings include: Review of the medical record revealed Resident #30 was admitted on [DATE] with diagnoses including dependence on renal dialysis, weakness, end stage renal disease, spinal stenosis, congestive heart failure, and dysphagia. Review of the care plan dated 05/30/25 revealed Resident #30 was at risk for falls/injury related to gait/balance problems and psychoactive drug use. Interventions included adequate lighting, appropriate shoes/nonslip socks, assess/monitor for side effects from psychoactive medications such as lethargy, maintain clear pathways, provide frequent reminders for the resident to ask for assistance before attempting standing or walking provide visual reminder to use call light to request assistance to the bathroom. New fall prevention interventions were implemented two days after readmission from the hospital including place a falling star magnet on doorway to alert staff to risk for frequent falls (initiated 10/08/25), and keep needed items in reach (initiated on 10/08/25). Review of the progress notes revealed on 10/02/25 at 10:25 P.M. Resident #30 was sent to the emergency room for an evaluation post fall, on 10/03/25 at 8:42 A.M. Resident #30 was admitted to the hospital, on 10/06/25 at 8:00 P.M. Resident #30 returned to the facility from the hospital, placed into her bed. Vital signs included blood pressure 115/60, temperature 97.7 degrees Fahrenheit (F), pulse 76, pulse 18, pulse ox 96. Resident #30 had nine staples to her head and a large bruise to coccyx due to fracture. The physician was notified of her return and medication changes. The full nursing admission assessment was not completed until 10/09/25 at 6:32 P.M. (three days after readmission). Review of the care plan revealed Resident #30 had acute pain related to a fracture of the sacrum and head laceration from 10/06/25 and interventions included: identify, record, and treat conditions which may increase pain; monitor, record, and report any signs or symptoms of non-verbal pain; and observe or report changes in usual routine. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #30 had fractures and other trauma, was cognitively intact, was dependent on facility staff for toileting, required moderate assistance for transfers, was frequently incontinent of bowel and bladder, required hemodialysis, and did not reject care. Review of the progress note dated 12/21/25 at 2:07 P.M. revealed at 12:10 P.M. a certified nursing assistant (CNA) reported an unwitnessed fall for Resident #30. Upon entry to room, the nurse noticed the resident lying on the floor on her right side. Resident #30 stated she did not know how she ended up on the floor from her wheelchair. A body assessment was completed, and no injuries to report. No head trauma noted, and the resident denied hitting her head. The resident complained of pain to the right lower extremity, no guarding, flinching or verbalized pain when extremity palpated. The resident was refusing to extend her limb. Vital signs were assessed, blood pressure 132/64, pulse 90, pulse ox 95% on room air, respirations 18, and temperature 97.4 degrees F. Resident #30 was assisted from floor to bed via two assists. Resident #30 was educated on using call light when needing or wanting to transfer from one seat to the next. Resident verbalized understanding. The physician was notified via secure messaging, and the resident's son was notified of the fall. Review of the fall investigation dated 12/21/25 at 2:31 P.M. revealed Resident #30 fell from her wheelchair to the floor, the wheelchair wheels were not locked, and it was not documented if the call light was within reach. An observation on 12/22/25 at 12:16 P.M. revealed the following: facility staff had left the room after delivering the lunch tray; Resident #30 was in her wheelchair with a tray table positioned over her and a lunch tray on the tray table ready to eat; the wheelchair appeared to rock with resident movement; on examination of the wheelchair the wheels were (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed unlocked; the call light was attached to the bed and not on Resident #30's person; and when asked if she could locate the call light, Resident #30 was unable to find its location. An interview on 12/22/25 at 12:26 P.M. with the Assistant Director of Nursing (ADON) revealed she would expect the wheelchair wheels to be locked for safety. The ADON verified the wheels were unlocked and the call light was not within reach. An interview on 12/22/25 at 12:35 P.M. with the Assistant Director of Nursing (ADON) revealed she would expect an admission assessment to be completed upon resident admission. The ADON verified the above findings. Review of the undated facility policy titled Charting and Documentation revealed all changes in the resident's medical condition were to be documented. Review of the facility policy titled admission Assessment and Follow Up: Role of the Nurse, dated 11/26/24, revealed the purpose of the procedure was to gather information about the resident's condition upon admission to manage the resident, initiate the care plan, and to complete assessment instruments. The admission assessment was to include a physical assessment of the following: eyes, ears, nose, and throat; head and neck; teeth and gums, cardiovascular; respiratory; neurological; musculoskeletal; gastrointestinal; genito-urinary; and skin. Additional observational assessments were to be completed including pain, fall risk, neurological, and behavioral.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview and review of the facility policy, the facility failed to establish and implement physician's orders for tube feed administration for Resident #9 and failed to check tube feed residuals prior to medication administration for Resident #44. This affected two residents (#9 and #44) out of two reviewed for enteral feedings. The facility census was 49. Findings include: 1. Review of the medical record for Resident #9 revealed an admission date of 06/23/25 with diagnoses including gastrointestinal hemorrhage, angiodysplasia of colon, dementia, gastrostomy status, dysphagia, and adult failure to thrive. Review of the enteral feeding care plan dated 06/23/25 indicated Resident #9 required a tube feeding due to resisting eating and swallowing problems. Interventions included monitoring and documenting signs or symptoms of intolerance to tube feeding (initiated 06/23/25), Registered Dietitian to evaluate quarterly and as needed (initiated 06/23/25), and tube feeding of Nutren 2.0 at a rate of 65 milliliters (ml) per hour for 12 hours from 6:00 P.M. to 6:00 A.M. and water flushes of 80 ml per hour during the feeding time (initiated 11/24/25). Review of the nutritional care plan dated 06/23/25 indicated Resident #9 had a nutritional problem or potential nutritional problem due to dementia, dysphagia, anemia, refusing most foods or fluids, pleasure foods diet, and feeding tube. Interventions included mechanical soft diet for pleasure foods (initiated 06/23/25), monitor and record oral intakes (initiated 06/23/25), Registered Dietitian to evaluate and make diet change recommendations as needed (initiated 06/23/25), and provide tube feeding and water flushes per physician's orders (initiated 06/23/25). Review of the nutrition progress note dated 11/24/25 at 9:33 A.M. revealed Resident #9 received continuous feedings of Nutren 2.0 at 60 ml per hour for 12 hours nocturnally with 30 ml per hour water flushes since 11/21/25. Resident #9's daily nutritional requirements were calculated as 1490 to 1630 calories, 50 to 60 grams of protein, and 1240 to 1485 ml of fluids. Due to negligible amounts of oral intakes of foods and fluids at meals, the tube feeding rate was being increased to 65 ml per hour with a water flush of 80 ml per hour while the tube feeding was running. Review of the physician's orders for December 2025 for Resident #9 identified orders for a regular diet with mechanical soft texture for pleasure foods only (effective 06/23/25), tube feeding to run for 12 hours daily from 6:00 P.M. to 6:00 A.M. (effective 11/21/25), and water flushes at 80 ml per hour while the tube feeding is running (effective 11/24/25). There were no active orders for a tube feeding formula or infusion rate. The most recent orders for tube feeding formula and infusion rate, Nutren 2.0 at 65 ml per hour, were discontinued on 12/05/25. Review of the meal intake records for Resident #9 revealed out of 67 meals documented in the previous 30 days, Resident #9 refused 16 meals, consumed 0-25% at two meals, consumed 26-50% at three meals, and consumed 76-100% at two meals. The meal intake records were marked as NPO (nothing by mouth) for three meals, marked as tube feeding for 39 meals, marked as resident not available for one meal, and marked as not applicable for one meal. The meal intake records indicated Resident #9's oral intakes at meals were insufficient to meet the calculated nutritional requirements. On 12/15/25 at 10:12 A.M., an interview with Resident #9's husband stated Resident #9 received tube feedings at night. On 12/16/25 at 6:02 A.M., an observation of Resident #9 revealed tube feeding formula Nutren 2.0 was infusing at a rate of 80 ml per hour. Resident #9 was lying flat on the bed while the tube feeding was infusing. On 12/16/25 at 6:14 A.M., an observation and interview with Licensed Practical Nurse (LPN) #202 verified Resident #9 was not properly positioned in bed for tube feeding administration. LPN #202 stated the bed should be at a 30-to-45-degree angle during tube feeding administration. LPN #202 also verified Nutren 2.0 was infusing at a rate of 80 ml per hour. On 12/16/25 at 2:38 P.M., an interview with Registered Dietitian (RD) #155 verified Resident #9 did not have any active physician's orders for a tube feeding formula or rate of infusion. RD #155 was unable (continued on next page)		

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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)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to state why there were no orders for a tube feeding formula or formula infusion rate. RD #155 stated there should be orders for Nutren 2.0 with an infusion rate of 65 ml per hour and water flushes of 80 ml per hour. Review of the facility's policy titled Appropriate Use of Feeding Tubes, dated 03/19/22, indicated tube feedings would be used as necessary to address malnutrition and dehydration, or when the resident's clinical condition deemed it medically necessary. The policy indicated residents fed by enteral means would receive appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia and dehydration. 2. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnosis including stroke, respiratory failure, dysphagia (difficulty swallowing), aphasia (a language disorder due to brain damage), hemiplegia (one-sided paralysis or weakness), hemiparesis (paralysis on one side of the body), and malnutrition. Review of the physician orders revealed Resident #44 was ordered the following: nothing by mouth (NPO) dated 07/13/25, continuous tube feed at 45 cubic centimeters (cc) per hour dated 07/14/25, flush gastrostomy tube with 40 milliliters of water before and after medication administration, and all oral medications were ordered to be given via gastrostomy (feeding tube). Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 was moderately cognitive impaired, had upper limb impairment on one side, required maximal assistance or was completely dependent on staff for care needs, did not reject care, and was always incontinent of bowel and bladder. Observation on 12/17/25 at 9:31 A.M. of medication administration revealed residual gastric contents were not checked prior to the administration of famotidine (a medication used to treat reflux) 20 milligram (mg) tablet, tamsulosin (a bladder medication) 0.4 mg, clopidogrel (a medication that stops platelets from sticking together) 75 mg, and polyethylene glycol (a laxative) powder 17 grams dissolved in eight ounces of water. An interview on 12/17/25 at 9:54 A.M. with LPN #210 verified the above findings. Review of the facility policy titled Medication Administration via Feeding Tube, dated 11/02/23 revealed before medication administration occurred the residual gastric contents were to be checked to ensure less than 150cc remained in the stomach.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to ensure post dialysis assessments were completed as required. This affected one resident (#30) out of one resident reviewed for dialysis. The facility census was 49. Findings include: Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses of dependence on renal dialysis, heart failure, and weakness. Review of the Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #30 had fractures and other trauma, was cognitively intact, was dependent on facility staff for toileting, required moderate assistance for transfers, was frequently incontinent of bowel and bladder, required hemodialysis, and did not reject care. Review of the physician orders revealed an order dated 10/09/25 to check vital signs and dialysis access site upon completion of dialysis as needed and an order dated 10/09/25 to check vital signs and dialysis access site upon completion of dialysis every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday. Review of the dialysis hand off communication report dated 11/14/25 revealed Resident #30 received dialysis that day. Review of the Treatment Administration Record (TAR) from 11/01/25 to 11/30/25 revealed the absence of post dialysis vital signs and site check on 11/14/25. Review of the dialysis hand off communication report revealed Resident #30 received dialysis on 12/02/25, 12/04/25, and 12/08/25. Review of the TAR from 12/01/25 to 12/22/25 revealed the absence of post dialysis vital signs and dialysis access site checks on 12/02/25, 12/04/25, and 12/08/25. An interview on 12/22/25 at 12:35 P.M. with the Assistant Director of Nursing verified the missing post dialysis vital signs and dialysis access site check for Resident #30. Review of the facility document titled Long-Term Care Facility Renal Dialysis Coordination Agreement, dated 11/09/23 revealed under the section Care of Access Site, the facility will help monitor the resident's access site. Review of the facility document titled Care of Residents Receiving Renal Dialysis, dated 04/12/23 revealed it is facility policy for residents who received dialysis to be monitored, which included access site assessment upon return from dialysis and vital signs were to be obtained upon return from dialysis.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure all controlled medication accounting logs were reconciled after/before each shift as well as ensuring medications were accurately reflected on the Medication Administration Records (MAR) and controlled medication accounting logs in the resident's medical record. This affected three (Residents #17, #45 and #51) of three reviewed for controlled medication usage. The facility census was 49. Findings include: 1. Review of the Narcotic Count Sheets (which detail and track controlled substances including the receipt, use, disposal and transfer of controlled substances) revealed the nurse going off shift was to document the time, shift, number of controlled medication cards, number of controlled count sheets, if they received any medications during their shift, disposed of any medications during their shift and sign. The incoming nurse would then verify the controlled medication cards and count sheets, document the time and sign their name. Review of the narcotic count sheets dated [DATE] through [DATE] revealed lack of documentation for the following: [DATE] at 7:00 P.M., the nurse going off shift did not sign for her shift. [DATE] at 7:00 A.M., the incoming nurse did not reconcile the number of medication cards or count sheets. [DATE] at 3:00 P.M., the incoming nurse did not reconcile the number of medication cards or count sheets. [DATE] at 7:00 A.M., the incoming nurse did not sign for her shift. [DATE] at 7:00 A.M., the nurse going off shift did not count the medication cards, count the sheets or sign for her shift. Interview on [DATE] at 11:40 A.M. with the Director of Nursing (DON) verified the narcotic count sheets were not completed in their entirety on [DATE], [DATE], [DATE] and [DATE]. Review of the facility policy titled, Controlled Substance, dated [DATE], revealed nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. 2. Review of the medical record for Resident #17 revealed an admission date of [DATE] with diagnoses including fractures of the left tibia and fibula, multiple sclerosis, diabetes and dependence on renal dialysis. Resident #17 expired at the hospital on [DATE] at 10:07 A.M. Review of the physician's orders for [DATE] for Resident #17 revealed an order for Hydrocodone-Acetaminophen (narcotic) 5-325 milligrams (mg), one tablet every six hours as needed for pain dated [DATE]. This order was discontinued on [DATE]. Review of the physician's orders for [DATE] for Resident #17 revealed an order for Hydrocodone-Acetaminophen 5-325 milligrams, one tablet every eight hours as needed for pain dated [DATE]. This order was discontinued on [DATE]. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for [DATE] for Resident #17 revealed an order for Hydrocodone-Acetaminophen 5-325 mg, one tablet every six hours as needed for pain dated [DATE]. This order was discontinued on [DATE] at 3:14 P.M. Review of the Medication Administration Record (MAR) for [DATE] for Resident #17 revealed she had received Hydrocodone-Acetaminophen 5-325 mg on [DATE] at 1:52 A.M., 10:53 A.M., and 9:10 P.M., on [DATE] at 7:10 P.M., on [DATE] at 4:57 P.M., on [DATE] at 3:10 P.M. and 2:55 P.M., on [DATE] at 12:37 A.M., on [DATE] at 2:16 P.M. and 7:40 A.M., on [DATE] at 3:18 A.M., on [DATE] at 10:05 A.M. and 4:02 P.M., on [DATE] at 12:44 A.M., 6:45 A.M., 12:45 A.M. and 7:14 P.M., on [DATE] at 5:53 A.M., on [DATE] at 4:00 P.M., on [DATE] at 2:32 A.M., 11:30 A.M., and 11:33 P.M., on [DATE] at 3:52 P.M., on [DATE] at 1:12 A.M., 7:57 A.M., and 4:45 P.M., and on [DATE] at 3:56 P.M. The MAR revealed she had received a total of 27 Hydrocodone-Acetaminophen 5-325 mg for pain during the month of [DATE]. Review of the controlled drug record for Resident #17 for Hydrocodone-Acetaminophen 5-325 mg, prescription number C4685519 revealed nine doses had been received on [DATE]. Nursing staff had documented Resident #17 received her first dose on [DATE] at 7:11 A.M. and received a total of 9 tablets through [DATE] at 7:10 P.M. Review of the controlled drug record for Resident #17 for Hydrocodone-Acetaminophen 5-325 mg, prescription number C4690167 revealed 30 doses had been received on [DATE]. Nursing staff had documented Resident #17 received the first dose of this prescription on [DATE] at 8:00 A.M. and the final dose on [DATE] at 2:35 A.M. There was one tablet wasted out of the 30 tablets. Due to the illegibility of the handwriting, the dates between the first and last dose were unable to be verified at times. Resident #17 had received a total of 29 tablets through [DATE] to [DATE]. Review of the controlled drug record for Resident #17 for Hydrocodone-Acetaminophen 5-325 mg, prescription number C4692789 revealed 14 doses had been received on [DATE]. Nursing staff had documented Resident #17 received the first dose of this prescription on [DATE] at 11:30 A.M. and the final dose on [DATE] at 3:56 A.M. There was a dose that had been documented after Resident #17 had passed away on [DATE] at 11:19 P.M. There were three unused tablets on this medication card. Resident #17 had received a total of 10 tablets through [DATE] through [DATE]. Interview on [DATE] at 8:37 A.M. with an anonymous staff member stated the narcotic counts were incorrect frequently. She stated there was a concern that a nurse had been forging other nurse's signatures. Interview on [DATE] at 11:40 A.M. with the Director of Nursing (DON) verified the MAR had shown Resident #17 received a total of 27 doses of Hydrocodone-Acetaminophen 5-325 mg while she was a resident in the facility. The DON also verified the controlled drug records for Resident #17 revealed she had received a total of 48 doses of Hydrocodone-Acetaminophen 5-325 mg while she was a resident in the facility. He stated the nursing staff were probably signing off the controlled drug record only and had forgotten to sign off the MAR. Interview on [DATE] at 9:18 A.M. with the Medical Director revealed she was unaware nursing staff were signing off the controlled drug record log and not documenting in the MAR. She stated she does not review the controlled drug record when reviewing residents' medical records. Review of the facility policy titled, Medication Administration, dated [DATE], revealed nursing staff (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to sign the MAR after the medication is administered. If the medication was a controlled substance, the nurse was to sign the narcotic book as well. 3. Review of the medical record for Resident #51 revealed an admission date of [DATE] with diagnoses including diabetes mellitus, congestive heart failure, chronic pain, peripheral vascular disease, hypertension and anxiety. Review of the physician's orders for Resident #51 revealed she had an order for Hydrocodone-Acetaminophen 5-325 milligrams (mg), one tablet every six hours as needed for pain dated [DATE] and discontinued on [DATE]. She also had an order for Hydrocodone-Acetaminophen 5-325 mg, take one tablet three times a day at 6:00 A.M., 1:00 P.M. and 8:00 P.M. for hand pain dated [DATE]. Review of the Medication Administration Record (MAR) for Resident #51 for [DATE] revealed she received Hydrocodone-Acetaminophen 5-325 mg every six hours as needed for pain on [DATE] at 9:22 P.M., on [DATE] at 9:38 P.M., on [DATE] at 9:20 A.M., on [DATE] at 9:32 A.M., on [DATE] at 9:34 A.M., on [DATE] at 12:05 P.M., on [DATE] at 9:11 A.M., on [DATE] at 10:22 A.M., on [DATE] at 4:30 A.M., on [DATE] at 4:30 A.M., on [DATE] at 12:55 P.M. and 8:28 P.M., on [DATE] at 6:51 P.M., on [DATE] at 8:38 P.M. and on [DATE] at 9:12 A.M. The MAR revealed she had received a total of 15 Hydrocodone-Acetaminophen 5-325 mg for pain as needed during the month of [DATE]. Review of the MAR for Resident #51 for [DATE] revealed she received Hydrocodone-Acetaminophen 5-325 mg three times a day for hand pain on [DATE] at 1:00 P.M. and 8:00 P.M., on [DATE] at 6:00 A.M., 1:00 P.M. and 8:00 P.M., on [DATE] at 6:00 A.M., 1:00 P.M. and 8:00 P.M., on [DATE] at 6:00 A.M., 1:00 P.M. and 8:00 P.M., and on [DATE] at 6:00 A.M., 1:00 P.M. and 8:00 P.M. The MAR revealed she had received a total of 14 Hydrocodone-Acetaminophen 5-325 mg during the month of [DATE]. Review of the controlled drug record for Resident #51 for Hydrocodone-Acetaminophen 5-325 mg, prescription number C4683946 revealed 30 doses had been received on [DATE]. Nursing staff had documented Resident #51 received her first dose on [DATE] at 9:22 P.M. and received a total of 30 tablets through [DATE] at 12:25 P.M. Review of the controlled drug record for Resident #51 for Hydrocodone-Acetaminophen 5-325 mg, prescription number C4683946 revealed 30 doses had been received on [DATE]. Nursing staff had documented Resident #51 received her first dose on this card on [DATE] at 12:30 A.M. and had received a total of 13 tablets through [DATE] at 8:43 P.M. Also, noted on this controlled drug record for Resident #51 there was documentation from nursing staff that stated they have administered this prescription of Hydrocodone-Acetaminophen 5-325 prior to the medication card and controlled drug record log arriving at the facility as there were dates noted of [DATE] at 11:00 P.M., [DATE] at 6:30 A.M., [DATE] at 6:00 A.M. and [DATE] at 1:00 P.M. Due to the illegibility of the handwriting, other dates were unable to be verified at times. Interview on [DATE] at 11:55 A.M. with the Director of Nursing (DON) verified the MAR had shown Resident #51 had received a total of 29 doses of Hydrocodone-Acetaminophen 5-325 mg during the month of [DATE]. The DON also verified the controlled drug records for Resident #51 revealed she had received a total of 43 doses of Hydrocodone-Acetaminophen 5-325 during the month of [DATE]. He stated the nursing staff were probably signing off the controlled drug record only and had forgotten to sign off the MAR. The DON would not verify the controlled drug record for Resident #51 received on [DATE] had some discrepancies related to back-dating of the medication being given before it had (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been received at the facility. He stated he believed it was a documentation error. Interview on [DATE] at 3:02 P.M. with Pharmacist #304 stated Resident #51's prescription for Hydrocodone-Acetaminophen 5-325, prescription number C44683946 was filled on [DATE] and sent to the facility the evening of the [DATE]. Interview on [DATE] at 8:37 A.M. with an anonymous staff member stated the narcotic counts were incorrect frequently. She stated there was a concern that a nurse had been forging other nurse's signatures. Interview on [DATE] at 9:18 A.M. with the Medical Director revealed she was unaware nursing staff were signing off the controlled drug record log and not documenting in the MAR. She stated she does not review the controlled drug record when reviewing residents' medical records. Review of the facility policy titled, Medication Administration, dated [DATE], revealed nursing staff was to sign the MAR after the medication is administered. If the medication was a controlled substance, the nurse was to sign the narcotic book as well. 4. Review of the medical record for Resident #45 revealed an admission date of [DATE] with diagnoses including severe intellectual disabilities, stage four pressure ulcer of the sacral region, and prostate cancer. Review of the physician's orders for Resident #45 identified orders for Percocet tablet 5-325 milligram (mg) to give one tablet via feeding tube every 12 hours as needed for pain (effective [DATE]). Review of the Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #45 had severe cognitive impairment. Review of the Medication Administration Record (MAR) for [DATE] indicated Resident #45 was administered Percocet on [DATE] at 10:48 A.M., [DATE] at 2:58 P.M., and [DATE] at 9:27 A.M. There was no other documentation of administration of Percocet on the MAR for [DATE]. Review of the controlled drug record for Resident #45's as needed Percocet (Oxycodone-APAP) 5-325 mg, prescription number C4682746 revealed 30 doses had been received on [DATE]. The controlled drug record indicated 28 tablets had been administered in total with 26 of those tablets signed out as administered in [DATE]: [DATE] at 10:00 A.M., [DATE] at 8:30 P.M., [DATE] at 9:00 A.M., [DATE] at 12:00 A.M., [DATE] at 10:00 A.M., [DATE] at 2:00 A.M., [DATE] at 9:23 P.M., [DATE] at 11:15 P.M., [DATE] at 10:30 A.M., [DATE] at an illegible time, [DATE] at an illegible time, [DATE] at 6:00 P.M., [DATE] at 11:00 P.M., [DATE] at 8:10 P.M., [DATE] at 1:00 A.M., [DATE] at 9:30 A.M., [DATE] at 9:00 A.M., [DATE] at 9:00 P.M., [DATE] at 10:15 P.M., [DATE] at 10:00 A.M., [DATE] at 10:10 P.M., [DATE] at an illegible time, [DATE] at 6:00 A.M., [DATE] at 10:00 P.M., [DATE] at 2:10 A.M., and [DATE] at 10:00 A.M. There were no Percocet tablets signed out on [DATE] or [DATE] and the MAR had indicated Percocet was administered on those days. On [DATE] at 12:22 P.M., an attempt was made to interview Resident #45, however, Resident #45 was not interviewable due to being unable to answer questions appropriately. On [DATE] at 12:11 P.M., an interview with the Director of Nursing (DON), with the Administrator and Regional Staff Educator #208 present during the interview, verified more Percocet tablets had been (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signed out on the controlled drug record than had been documented on the MAR for Resident #45. The DON confirmed there were 26 Percocet tablets signed out on the controlled drug record and only three recorded administrations on the MAR. The DON was unable to state how staff were determining the effectiveness of the pain medication administration since they were not even documenting the administration in the electronic medical record. On [DATE] at 9:18 A.M., an interview with the Medical Director revealed she was unaware nursing staff were signing off the controlled drug record log and not documenting in the MAR. She stated she does not review the controlled drug record when reviewing residents' medical records. Review of the facility policy titled, Medication Administration, dated [DATE], revealed nursing staff was to sign the MAR after the medication is administered. If the medication was a controlled substance, the nurse was to sign the narcotic book as well.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, interviews, and review of facility policy, the facility failed to ensure Resident #51 was free of significant medication errors. This affected one resident (Resident #51) of nine residents reviewed for medication administration. The facility census was 49. Findings include: Review of the medical record for Resident #51 revealed an admission date of 02/21/23 with diagnoses including diabetes mellitus, congestive heart failure, schizophrenia, peripheral vascular disease, hypertension and anxiety. Review of the physician ' s orders for Resident #51 revealed orders for Dextromethorphan-Bupropion ER (medication for major depressive disorder) 45-105 milligrams (mg) in the morning dated 06/04/25; Hydralazine HCL (medication for high blood pressure) 50 mg three times daily dated 06/04/25; Hydroxyzine HCL (medication for anxiety) 25 mg three times daily dated 06/15/25; Pancrelipase (medication used to treat exocrine pancreatic insufficiency which is a condition where the pancreas does not produce enough digestive enzymes) 24,000-76,000 units three times daily dated 07/15/24; Ticagrelor (antiplatelet medication used to prevent serious cardiovascular events such as heart attack and stroke) 90 mg two times a day dated 07/15/25; Buspirone HCL (medication for anxiety) 15 mg three times daily dated 07/17/25; Carbidopa-Levodopa (medication for Parkinson ' s Disease) 25-100 mg three times daily dated 08/01/25; Aripiprazole (anti-psychotic medication used to treat schizophrenia) 2 mg, take two tablets at 8:00 A.M. dated 10/17/25. Review of the Medication Administration Record (MAR) for Resident #51 for November 2025 revealed she did not receive Bupropion ER 45-105 mg on 11/13/25 in the morning; Hydroxyzine HCL 25 mg on 11/09/25 and 11/10/25 at 6:00 A.M.; Hydralazine HCL 50 mg on 11/10/25 and 11/12/25 at 8:00 P.M., on 11/11/25 and 11/12/25 at 1:00 P.M. and on 11/13/25 at 6:00 A.M.; Pancrelipase 24,000-76,000 units on 11/03/25 and 11/14/25 at 6:00 A.M. and on 11/25/25 at 4:00 P.M.; Ticagrelor 90 mg on 11/10/25 at 8:00 P.M. and 11/13/25 at 8:00 A.M.; Buspirone HCL 15 mg on 11/10/25 and 11/12/25 at 8:00 P.M., 11/12/25 at 1:00 P.M., and on 11/12/25 and 11/13/25 at 6:00 A.M.; Carbidopa-Levodopa 25-100 mg on 11/10/25 at 8:00 P.M., 11/12/25 at 1:00 P.M. and on 11/13/25 at 6:00 A.M.; and Aripiprazole 2 mg at 8:00 A.M. on 11/04/25 and 11/05/25. These medications that were not administered were documented in her medical record as unavailable due to waiting on the medication from the pharmacy. Interview on 12/17/25 at 9:28 A.M. with Nurse Practitioner (NP) #301 revealed she had noticed medications were unavailable frequently. NP #301 stated staff were not updating her when medications were not available to be administered. Interview on 12/17/25 at 11:55 A.M. with the Director of Nursing (DON) verified the above medications were not administered as ordered and the physician or nurse practitioner were not updated on medications not being available. Review of the facility policy titled, Medication Administration, revised 06/18/24, revealed medications were to be administered as ordered.		

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 12/31/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure urinary catheter bags were placed in a manner to prevent contamination and risk of infection for Resident #43. This affected one resident (#43) of one resident reviewed for catheter care. The facility census was 49. Findings include: Review of the medical record for Resident #43 revealed an admission date of 01/15/25 with diagnoses including vascular dementia, benign prostatic hyperplasia with lower urinary tract symptoms, hematuria, and neuromuscular dysfunction of the bladder. Review of the care plan, date initiated 02/03/25, revealed Resident #43 was at risk for urinary retention, painful urination, and frequent urination due to a diagnosis of benign prostatic hyperplasia and had an indwelling catheter due to urinary retention. Interventions included foley catheter and follow catheter care per orders or policy, check tubing for kinks, monitor and document intake and output, monitor for signs or symptoms of discomfort with urination and frequency, monitor and document for pain or discomfort due to catheter, and monitor and record signs or symptoms of urinary tract information and report to the physician. Review of the physician's orders for Resident #43 identified orders to irrigate catheter with 50 to 100 milliliters (ml) of normal saline solution for occlusion as needed (effective 03/19/25), urinary catheter size 30 to be changed monthly (effective 11/19/25), and change urinary catheter drainage bag monthly with catheter change (effective 11/19/25). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #43 had moderately impaired cognition and required an indwelling catheter. On 12/17/25 at 8:17 A.M., an observation of Resident #43 revealed his catheter bag was laying on the floor under his wheelchair while he was sitting in the hallway by the nurses station. An interview at the time of observation with Licensed Practical Nurse (LPN) #120 verified Resident #43's catheter bag was on the floor under his wheelchair and the catheter bag should not be touching the floor. On 12/17/25 at 12:02 P.M., an interview with the Director of Nursing (DON) stated the facility did not have a policy regarding catheter bag placement or storage during use.		