STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365791	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanctuary at Ohio Valley	2932 South 5th Street Ironton, OH 45638

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on medical record review and staff interview, the facility failed to ensure resident Pre-Admission Screening and Resident Review (PASRR) documents were accurate to resident current conditions and diagnoses. This affected one (Resident #5) of three residents reviewed for PASRR documents. The census was 79. Findings Include: Resident #5 was admitted to the facility on [DATE]. Her diagnoses were cerebral infarction, diabetes mellitus type II, muscle weakness, abnormal posture, constipation, atrial fibrillation, unspecified psychosis, hypertension, Chronic Obstructive Pulmonary disease, hyperlipidemia, anxiety, depression, renal dialysis, chronic kidney disease, arteriovenous fistula, end stage renal disease, and morbid obesity. Review of her Minimum Data Set (MDS) assessment, dated 01/28/25 revealed she had minimal cognitive impairment. Most recent PASSR was completed on 11/29/23 with a diagnosis of mood disorder. A new diagnosis of unspecified psychosis was added on 04/12/24 and a new PASSR was not completed with the addition of the new diagnosis. Interview with the Assistant Director of Nursing #180 on 03/05/25 at 09:37 A.M. verified a new PASSR should have been completed with the addition with the new diagnosis of unspecified psychosis.

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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NAME OF PROVIDER OR SUPPLIER Sanctuary at Ohio Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 2932 South 5th Street Ironton, OH 45638	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview, medical record review and facility policy review the facility failed to ensure Resident #59 had a physicians order for oxygen therapy. This affected one (Resident #59) of one residents reviewed for respiratory care. The facility census was 79. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disorder, chronic pulmonary embolism, and hypertension. Review of the physician orders dated 03/25 revealed Resident #59 did not have an order for oxygen therapy. Resident #59 had an order for Bilevel positive airway pressure (BiPap), a mechanical breathing device, to be worn as tolerated except during meals. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #59 was cognitively intact and refused care four to six days of look back period. Resident #59 was depended on staff for completion of most activities of daily living. Resident #59 received oxygen therapy and used a non invasive mechanical ventilator-BiPap. Review of the plan of care revised on 12/09/24 revealed Resident #59 had oxygen therapy related chronic obstructive pulmonary disorder with shortness of breath with exertion and when lying flat. Oxygen to be applied per order, continuously, via nasal cannula. The goal stated Resident #59 oxygen saturation level would be kept as desired levels as set by the physician through the review date. The interventions included to administer oxygen as ordered, provide aerosol treatments as ordered, change oxygen tubing per facility guidelines, keep the head of bed elevated to residents comfort level to relieve or prevent shortness of breath, medications as ordered, monitor oxygen saturation level as ordered and observe for signs and symptoms of dyspnea. Observations on 03/03/25, 03/04/25 and 03/05/25 confirmed Resident #59 was receiving oxygen at four liters per minute via nasal cannula. Interview on 03/03/25 at 2:17 P.M. with Resident #59 confirmed he was wearing oxygen at four liters per minute via nasal cannula. Interview on 03/05/25 at 10:10 A.M. with Unit Manager #840 confirmed Resident #59 was wearing oxygen at four liters per minute via nasal cannula and Resident #59 did not have an order for oxygen via nasal cannula. Review of the facility policy titled Oxygen Administration without a date revealed oxygen wa administered under orders of a physician unless an emergency.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview, medical record review, and facility policy review the facility failed to ensure Resident #80 had physician order for dialysis treatment and care. This affected one (Resident #80) of two residents reviewed for dialysis. The facility census was 79. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE] with diagnoses including acute kidney failure with tubular necrosis, chronic kidney disease stage five, hypertension and congestive heart failure. Review of the physician orders dated 03/25 revealed Resident #80 did not have a physician order for dialysis treatment, the name of the facility or contact information and no orders for care and treatment of dialysis port. Review of the nursing progress notes from 02/10/25 through 03/05/25 revealed one note on 02/28/25 at 3:40 P.M. indicated the local dialysis center was notified of Resident #80 discharge date of [DATE] from the facility and residents request for chair time change. No other progress notes addressing Resident #80 leaving the facility or returning from dialysis treatment. Review of the admission Medicare five day Minimum Data Set (MDS) dated [DATE] revealed Resident #80 was cognitively intact with no behaviors. Resident #80 required staff assistance with activities of daily living. The MDS did not indicate Resident #80 was receiving dialysis treatment. Review of the facility provided communication sheets between the facility and dialysis confirmed Resident #80 received dialysis treatment on Tuesday, Thursday and Saturday of each week. Review of the plan of care dated 02/25/25 revealed Resident #80 had renal failure but the plan of care did not include information related to dialysis treatment. Interview on 03/04/25 at 2:45 P.M. with Resident #80 confirmed he was feeling bad (tired) after returning from dialysis treatment. Interview on 03/05/25 at 10:10 A.M. with Unit Manager #840 confirmed Resident #80 had dialysis treatment three times per week. Unit Manager #840 also confirmed Resident #80 did not have orders for dialysis treatment, dialysis treatment center information or care of dialysis site. Unit Manager #840 confirmed the orders were placed in Resident #80 medical record on this date of 03/05/25. Review of the facility policy titled Hemodialysis with no date revealed the physician order for dialysis would include the type of access for dialysis and location, the dialysis schedule, the nephrologist name and phone number, the dialysis facility name and phone number, the transportation arrangement to and from the dialysis facility, any medication administration or withholding of specific medications prior to dialysis treatments and any fluid restriction if ordered by the physician.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record reviews and interviews, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the cause of the residents PTSD and minimize triggers and/or re-traumatization. This affected two residents (#23 and #70) out of two residents identified by the facility as having PTSD/trauma. The facility census was 79. Findings include: 1. Record review for Resident #23 revealed the resident was admitted to the facility on [DATE] and had diagnoses including cerebrovascular disease, acute and chronic respiratory failure, hyperlipidemia, insomnia, anxiety, depression, peripheral vascular disease, hypertension, atherosclerosis, Post-Traumatic Stress Disorder (on 5-9-18), transient ischemic attack, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment, dated 02/11/25, revealed this resident was assessed to have intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. This resident was assessed to have an active diagnosis of PTSD. Review of the active care plans for Resident #23 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #23 and to identify potential triggers which may cause re-traumatization. Interview with the Social Services Director #210 on 03/04/25 at 03:34 P.M. verified an assessment of the cause of PTSD and possible triggers for Resident #23 had not been completed and there were no plan of care created to address causes and triggers of PTSD. 2. Record review for Resident #70 revealed the resident was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis, atrial fibrillation, aphagia, gastro-esophageal reflux disease, muscle weakness, hyperlipidemia, right hand contracture, Post-Traumatic Stress Disorder (added 5-29-24), benign prostatic hyperplagia, constipation, depression, hypertension, hypothyroidism, and low back pain. Review of the Minimum Data Set (MDS) assessment, dated 02/06/25, revealed this resident was assessed to have moderate cognitive impairment evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 9. This resident was assessed to have an active diagnosis of PTSD. Review of the active care plans for Resident #70 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #70 and to identify potential triggers which may cause re-traumatization. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Services Director #210 on 03/04/25 at 03:34 P.M. verified an assessment of the cause of PTSD and possible triggers for Resident #70 had not been completed and there were no plan of care created to address causes and triggers of PTSD.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview, medical record review and facility policy review the facility failed to ensure Resident #22 and Resident #72 had low blood sugar parameters and directions of action when obtaining accucheck blood sugars with sliding scale insulin. This affected two (Resident #22 and Resident #72) of five residents reviewed for unnecessary medications. The facility census was 79. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including cerebrovascular disease, diabetes mellitus type two, schizoaffective disorder, hypothyroidism and mood disorder. Review of the physician orders dated 03/25 revealed Resident #22 received Novolog (fast acting insulin) injection solution 100 units per milliliter (ml) per sliding scale. Inject insulin subcutaneously before meals and at bedtime. Inject as per sliding scale if blood sugar was 200-249 give two units, 250-299 give four units, 300-349 give six units, 350-400 give 8 units, 401-450 give 10 units and call the physician or Nurse Practitioner for further orders. The order did not include a low blood sugar parameter or what to do if blood sugar was low. Review of the nursing progress notes from 01/01/25 through 03/05/25 was silent on Resident #22 blood sugar results. Review of the plan of care revised on 04/18/23 revealed Resident #22 had altered endocrine status related to diabetes mellitus and hypothyroidism. The goal for Resident #22 was blood sugars to remain at acceptable level through review date. The interventions included to be alert to medications that may cause changes in resident's blood sugar levels such as steroids, potassium and some antibiotics, monitor blood sugar as needed for symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) for example change in hunger, thirst, or anxiety, change in level of consciousness, fruity breath and alterations in urinary patterns, administer diabetes medication as ordered, educate resident/family/caregiver that compliance was essential to prevent complications of diabetes, nails should be cut straight across and obtain fasting blood glucose levels as ordered by physician. Interview on 03/06/25 at 9:24 A.M. with Licensed Practical Nurse (LPN) #490 confirmed a low blood sugar would be 70 or below but based on the residents normal. LPN #490 also had knowledge on procedure for low blood sugar and confirmed Resident #22 did not have orders to include what a low blood sugar reading was or instructions of what to do. 2. Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses including rheumatic mitral stenosis, diabetes mellitus type two, shortness of breath, anxiety, depression and dementia. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders dated 03/25 revealed Resident #72 received Humalog solution (fast acting insulin) 100 units per ml, inject subcutaneously before meals and at bedtime. Inject per sliding scale: 200-249 give two units, 250-299 give four units, 300-349 give six units, 350-399 give eight units, 400 plus give 10 units and call physician for further orders. The order did not include a low blood sugar parameter or what to do if blood sugar was low. Review of the nursing progress notes from 01/01/25 through 03/05/25 revealed no documentation of blood sugar results. Review of the Medicare five day Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was cognitively impaired with no behaviors. Resident #72 required assistance from staff to complete activities of daily living. Resident #72 had diagnosis of diabetes mellitus and received four insulin injections during the look back period. Review of the plan of care revised on 07/25/24 revealed Resident #72 had altered endocrine status related to diabetes mellitus. The goal was blood sugars would remain at acceptable levels for resident through review date. The interventions included to monitor blood sugars as needed for symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) such as change in hunger, thirst and anxiety, change in level of consciousness, fruity breath and alteration in urinary pattern, administer diabetes medication as ordered by physician, monitor for compliance with diet and document any problems. Interview on 03/06/25 at 9:24 A.M. with Licensed Practical Nurse (LPN) #490 confirmed a low blood sugar would be 70 or below but based on the residents normal. LPN #490 also had knowledge on procedure for low blood sugar and confirmed Resident #72 did not have orders to include what a low blood sugar reading was or instructions of what to do. Review of the facility policy titled Timely Administration of Insulin did not address parameters for low and high blood sugar or directions for care.