STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to ensure the physician was notified of weight gain, low blood pressure and a change in appetite. This affected two (Resident's #5 and #27) of six residents reviewed for notification of changes. The census was 26. Findings include: 1. Review of Resident #5's medical record revealed an 11/20/24 admission with diagnoses including fractured right femur, moderate protein calorie malnutrition, heart failure, asthma, acute cholecystitis, hypertension, hyperlipidemia, atherosclerotic heart disease, paroxysmal atrial fibrillation, anemia, and gastroesophageal heart disease. Review of the 11/27/24 Admission Minimum Data Set Assessment revealed the resident was independent for daily decision making, had an active diagnosis of heart failure and received opioid medication. Physician orders included an admission order to notify the physician if you have a weight gain two pounds in a day or three to five pounds in one week everyday and document weight and notify physician. Review of the weight record revealed on 12/05/24 the resident weighed 162.8 pounds. On 12/06/24 the resident weighed 166 pounds, a 3.2 pound weight gain. Review of the record revealed no evidence of the physician being notified of a greater than two pound weight gain. The resident gained 3.2 pounds in one day. Interview 12/20/24 at 5:32 P.M. with the Director of Nursing revealed there was no evidence of the physician being notified of the weight gain of 3.2 pounds. The Director of Nursing included she had the weight gain on the rounds sheet but did not document the notification as ordered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #27's closed medical record revealed a 10/25/24 admission for skilled rehabilitative services following a hospitalization for a right total knee replacement that was performed on 10/23/24. Resident #27 had diagnoses including chronic kidney disease (CKD) Stage 3 (moderate to severe kidney damage), encounter for orthopedic aftercare right knee replacement, vertigo, hypertension, gout, hyperlipidemia, Vitamin D deficiency, obesity, restless leg syndrome, major depressive disorder, unilateral primary osteoarthritis of the right knee, tremor, anxiety disorders and a personal history of a pulmonary embolism. Review of the admission physician's orders included orders for regular diet/regular texture, Propranolol HCl Oral Tablet 10 mg one tablet by mouth two times a day related to essential primary hypertension with parameters to hold for systolic blood pressure less than 100 mmHg, Lisinopril-Hydrochlorothiazide 20-25 mg one tablet by mouth one time a day related to essential primary hypertension with parameters to hold for systolic blood pressure less than 100 mmHg. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident as independent for decision making and no cognitive deficits with a 15 out of 15 BIMS score. Review of the resident meal intake percentage in the Certified Nurse Aide (CNA) electronic medical record (EMR) revealed between 10/25/24 admission and breakfast on 10/30/24 the resident ate 26-50% of her meal once, 51-75% of five meals and 76-100% of 11 meals. The resident ate zero to 25% of her lunch on 10/30/24. Review of a nurse's note dated 10/30/24 at 1:31 P.M. by Licensed Practical Nurse (LPN) #82 included Gastrointestinal Note: Resident had a bout of watery diarrhea. tested for both COVID and the influenza, both test results were negative. Nutrition: Taking nutrition and hydration orally. No complaints of thirst. No signs /symptoms of a swallowing disorder. The resident's mucous membranes were moist. Vital signs within normal limits. Review of the resident meal tracker revealed a zero for supper 0-25% was eaten on 10/30/24. She had a large loose/ diarrhea stool at 6:18 P.M. and 500 milliliters (ml) of fluid intake documented for the day. Review of an alert note by LPN #82 dated 10/30/24 at 6:18 P.M. revealed Resident #27 ate 50% or less for two or more meals in the day. Resident is encouraged to increase her intake. Review of the medical record for Resident #27 revealed resident ate 51-75% of her breakfast on 10/31/24. Review of a Health Status Note by Registered Nurse (RN) #80 dated 10/31/24 at 10:30 A.M. revealed the resident reported that she has been having loose stools this weekend and upset stomach. This was reported to physician via secure conversation. An order was written for as needed Imodium for diarrhea at 11:06 A.M. There was no evidence of the Imodium being administered. There was no evidence of the physician being notified of the change in meal intake. Review of the medication administration record (MAR) revealed the resident's morning anti-hypertensive medications Lisinopril and Propranolol were held on 10/31/24 for a systolic blood pressure less than 100. Her blood pressure was documented to be 87/50 (hypotensive). Record review revealed no evidence the physician or nurse practitioner were notified at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident meal tracker revealed a zero for lunch 0-25% was eaten on 10/31/24. Review of the resident meal tracker revealed a zero for supper 0-25% was eaten on 10/31/24. The total fluid intake was 460 ml for the day. Review of an Alert Note dated 10/31/24 by RN #84 indicated Resident #27 ate 50% or less for two or more meals in the day. Resident #27 was encouraged to consume more during her mealtimes, alternatives and snacks offered. There was no evidence of the physician being notified of the second alert for decreased meal intake. Review of the resident meal tracker revealed a zero for breakfast 0-25% was eaten 11/01/24. There was no evidence of the physician being notified of a poor appetite for five of the last six meals. During an interview with the Medical Director (MD) on 12/19/24 at 11:18 A.M. the MD verified she was not made aware of the decreased meal intake and hypertensive medications being held. Review of facilities Notification of Change in Resident Condition Policy dated 05/21/15 revealed to promptly notify the attending physician of changes in resident's medical condition. This deficiency represents non-compliance investigated under Complaint Number OH00160184.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on closed record review, review of emergency room /hospital records, policy review, and interview the facility failed to adequately monitor and provide timely and necessary care and services for an acute change in condition for Resident #27. Actual harm occurred beginning on [DATE] when Resident #27, who had chronic Stage 3 kidney disease, was noted to have an acute change in condition (nausea, vomiting, diarrhea, fatigue and decreased appetite) that was not adequately treated. Between [DATE] and [DATE], the resident continued to exhibit a deterioration in condition including hypotension, poor oral intake and nausea/vomiting and diarrhea. The resident was transported to the emergency roiagnom on [DATE] and admitted to the intensive care unit with diagnoses of sepsis, acute kidney injury, primary hypertension, hyperlipidemia, benign essential tremors, and atrial fibrillation. Diagnoses of dehydration, urinary retention and diarrhea were pertinent upon presentation to the emergency room . The resident expired two days later with cause of death being multiple organ failure, severe lactic acidemia requiring hemodialysis, acute kidney injury, and colitis. This affected one resident (#27) of three residents reviewed for incontinence. The facility census was 26. Findings include: Review of Resident #27's closed medical record revealed a [DATE] admission for skilled rehabilitative services following a hospitalization for a right total knee replacement that was performed on [DATE]. Resident #27 had diagnoses including chronic kidney disease (CKD) Stage 3 (moderate to severe kidney damage), encounter for orthopedic aftercare right knee replacement, vertigo, hypertension, gout, hyperlipidemia, Vitamin D deficiency, obesity, restless leg syndrome, major depressive disorder, unilateral primary osteoarthritis of the right knee, tremor, anxiety disorders and a personal history of a pulmonary embolism. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the admission physician's orders included orders for Acetaminophen Tablet give 650 milligrams (mg) by mouth every four hours as needed for mild pain (may give (2) two tablets to equal 650 mg every four hours) as needed. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), narcotic, one tablet by mouth every four hours as needed for pain - moderate related to encounter for orthopedic aftercare AND give two tablets by mouth every four hours as needed for pain - severe related to encounter for orthopedic aftercare, regular diet/regular texture, Simvastatin 40 mg at bedtime, Eliquis, anticoagulant, 2.5 mg related to a personal history of pulmonary embolism, snack at bedtime, occupational and physical therapy evaluation and treat, Propranolol HCl Oral Tablet 10 mg one tablet by mouth two times a day related to essential primary hypertension with parameters to hold for systolic blood pressure less than 100 mmHg, Lisinopril-Hydrochlorothiazide ,d+[DATE] mg one tablet by mouth one time a day related to essential primary hypertension with parameters to hold for systolic blood pressure less than 100 mmHg. The resident had orders for laboratory testing including a complete blood count with differential weekly on Mondays for four weeks starting [DATE] through [DATE], a complete metabolic panel weekly on Mondays for four weeks ([DATE] through [DATE]), and weigh resident every week for four weeks on Monday [DATE]-[DATE]. On [DATE] an order was written for Loperamide HCl Capsule 2 mg, one capsule by mouth as needed for loose stool. May give one capsule following each loose stool. Not to exceed eight capsules per day. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident as independent for decision making and no cognitive deficits with a 15 out of 15 BIMS score. Review of a Dehydration Risk Evaluation dated [DATE] included the resident had dementia, congestive heart failure, diabetes, renal disease, and liver disease. Dehydration Risk Score was two. When the score value was four or above the resident was at risk for dehydration. Review of a nurse practitioner's initial visit note dated [DATE] with Resident #27 on [DATE] revealed the resident initially presented to the hospital on [DATE] for a right total knee arthroplasty. There were no complications during surgery. Follow up at the surgeon's office on [DATE]. Today, she was seen and examined sitting in a wheelchair in no apparent distress. The resident described her pain as a 5-,d+[DATE]. She does have some edema to her affected leg. No other complaints at this time. Mouth: mucous membranes moist, no obvious oral sores. Chronic Kidney Disease (CKD): Creatinine 1.7 in hospital, baseline appears to be 1.5. Continue to monitor labs. Hypertension: Continue: Lisinopril, Hydrochlorothiazide. Monitor blood pressures and adjust medications as needed. Tremors: Present at baseline. Continue Propranolol. Review of laboratory testing revealed Resident #27 had a creatine level (waste product in body excreted in urine), of 1.7 milligrams per deciliter (mg/dl) normal level 0XXX,d+[DATE].5 mg/dl, on [DATE] with an estimated Glomerular Filtration rate (EGFR), (a test that estimates how well your kidneys were filtering waste and extra water) of 30 milliliters/minute (ml/min) (normal >60). On [DATE] the creatinine level was 1.6 mg/dl and EGFR 33 prior to admission to the facility. Laboratory testing [DATE] revealed a creatinine of 1.7 mg/dl and EGFR 28.1 ml/min. Review of the electronic medical record (EMR) revealed on [DATE] the physician reviewed the Complete Blood Count/Comprehensive Metabolic Panel and ordered an Iron Profile for [DATE]. The physician did not see/assess Resident #27 during her stay at the facility. Review of nurse practitioner note dated [DATE] at 9:14 A.M. revealed the resident had no complaints of nausea, vomiting or diarrhea. The [DATE] laboratory test was reviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the physical therapy notes revealed on [DATE] the resident was seen at 9:25 A.M. The note included Resident #27 complained of increased fatigue throughout. Review of the resident meal intake percentage in the Certified Nurse Aide (CNA) electronic medical record (EMR) revealed between [DATE] admission and breakfast on [DATE] the resident ate ,d+[DATE]% of her meal once, ,d+[DATE]% of five meals and ,d+[DATE]% of 11 meals. The resident ate zero to 25% of her lunch on [DATE]. Review of a nurse's note dated [DATE] at 1:31 P.M. by Licensed Practical Nurse (LPN) #82 included Gastrointestinal Note: Resident had a bout of watery diarrhea. tested for both COVID and the influenza, both test results were negative. Nutrition: Taking nutrition and hydration orally. No complaints of thirst. No signs /symptoms of a swallowing disorder. The resident's mucous membranes were moist. Vital signs within normal limits. Review of the bowel record in the EMR revealed the resident was continent of bowel until [DATE]. She had a large, formed continent stool [DATE] at 12:12 P.M. A large loose/diarrhea stool was documented at 2:11 P.M. , and a medium loose/diarrhea at 2:11 P.M. Review of the resident meal tracker revealed a zero for supper ,d+[DATE]% was eaten on [DATE]. She had a large loose/ diarrhea stool at 6:18 P.M. and 500 milliliters (ml) of fluid intake documented for the day. Review of an alert note by LPN #82 dated [DATE] at 6:18 P.M. revealed Resident #27 ate 50% or less for two or more meals in the day. Resident is encouraged to increase her intake. Did have a bout of nausea, diarrhea, and emesis. Review of the facility's standing house orders revised on [DATE] included the following orders may be initiated without contacting the physician. The physician must be contacted if orders are used for allergic reaction, hyperglycemia, chest pain, discomfort, or oxygen is initiated. The orders included for diarrhea Imodium for diarrhea one tablet after each loose stool not to exceed eight doses in 24 hours and for nausea and vomiting Phenergan 25 mg intramuscular (IM) every four hours for nausea vomiting, if no improvement in 24 hours notify physician. Review of the medical record revealed there was no evidence medications were initiated for nausea, vomiting and diarrhea on [DATE] to Resident #27. Review of the medical record for Resident #27 revealed resident ate ,d+[DATE]% of her breakfast on [DATE]. Review of Resident #27's care conference dated [DATE] at 10:00 A.M. revealed the resident's daughter joined by phone. The note included Resident #27 stated she has been having diarrhea for the last recent few days and daughter had questions re: blood work done in hospital. Nursing notified of questions. Review of the signature sheet revealed the social worker, physical therapy assistant and dietary were present at the meeting. Nursing was not present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Health Status Note by Registered Nurse (RN) #80 dated [DATE] at 10:30 A.M. revealed the resident reported that she has been having loose stools this weekend and upset stomach. This was reported to physician via secure conversation. An order was written for as needed Imodium for diarrhea at 11:06 A.M. There was no evidence of the Imodium being administered. Review of a physical therapy note dated [DATE] timed 10:00 A.M. till 10:44 A.M. by Physical Therapy Assistant, Therapy Manager #129 included the writer attending the resident's care conference where the resident reported an increase in diarrhea and difficulty with pain management. Discussed new signs and symptoms with nursing for further assessment and possible orders for antidiarrheal medication. Resident continued to be unable to get out of bed today due to complaint of increased weakness and uncontrolled diarrhea. Discussed Tylenol for breakthrough pain to avoid upset stomach. Applied ice to right knee for pain management. Review of the EMR revealed the resident was incontinent of a large loose/diarrhea stool documented on [DATE] at 11:36 A.M. Review of the medication administration record (MAR) revealed the resident's morning anti-hypertensive medications Lisinopril and Propranolol were held on [DATE] for a systolic blood pressure less than 100. Her blood pressure was documented to be ,d+[DATE] (hypotensive). Record review revealed no evidence the physician or nurse practitioner were notified at this time. Review of the resident meal tracker revealed a zero for lunch ,d+[DATE]% was eaten on [DATE]. Review of an Occupational Therapy Assistant #130 note dated [DATE] at 2:20 P.M. revealed the resident missed a session due to an episode of vomiting and repeated episodes of diarrhea when attempting to move. Review of Nurse Skilled Evaluation note dated [DATE] at 3:40 P.M. written by the Director of Nursing revealed the resident's blood pressure was ,d+[DATE] at 12:28 P.M. in the lying position, pulse 74 beats per minute, respirations 18 per minute, temperature 97.4 degrees Fahrenheit and oxygen saturation 97%. The resident had stabbing aching pain in the right knee; pain level of five on a scale of ,d+[DATE] with 10 being the worst pain. A cool compress was applied without affect and pain medication was administered. Resident follows commands. Denies weakness, tremors, numbness or tingling. Alert and oriented times three, communicated verbally, speech is clear, able to understand and be understood when speaking. No difficulty breathing. No cough noted. No shortness of breath noted. Abdomen flat, and non-tender. Bowel sounds present times four. Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Taking nutrition and hydration orally. No complaints of thirst. No signs /symptoms of a swallowing disorder. Mucous membranes moist. Resident continent of bladder. Urine clear yellow. Denies urinary complaints. Skin warm and dry, skin color within normal limits and turgor is normal. Right front knee surgical wound incision well approximated. Gait is unsteady. Physical Therapy: Resident continues to participate in therapy as ordered. Physical Therapy: Resident is improving. Occupational therapy: Resident continues to participate in therapy as ordered. Resident #27 is improving. Review of the resident meal tracker revealed a zero for supper ,d+[DATE]% was eaten on [DATE]. The total fluid intake was 460 ml for the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an Alert Note dated [DATE] by RN #84 indicated Resident #27 ate 50% or less for two or more meals in the day. Resident #27 was encouraged to consume more during her mealtimes, alternatives and snacks offered. Review of the [DATE] 9:15 P.M. Skilled Nurse note dated [DATE] at 9:15 P.M. by LPN #92 revealed a blood pressure of ,d+[DATE]. Vital signs were within normal limits. The assessment had no changes in condition since the 3:40 P.M. assessment. Review of the EMR indicated the resident was incontinent of a large loose/diarrhea stool on [DATE] documented at 6:30 A.M. There was no evidence that Imodium was administered as ordered. Review of the resident meal tracker revealed a zero for breakfast ,d+[DATE]% was eaten [DATE]. Review of note dated [DATE] by Certified Occupational Therapy Assistant (COTA) #130 revealed the resident received therapy between 9:00 A.M. and 9:30 A.M. The resident complained of diarrhea with movement, flat effect, and shallow breathing, Consulted nursing. Blood pressure low, decreased bowel sounds. The resident was returned to room to be sent to the hospital. Review of Physical Therapy note dated [DATE] timed 9:45 A.M. till 10:00 A.M. by Physical Therapy Assistant, Therapy Manager #129 included nursing performed a routine assessment on the resident due to her blood pressure being low the last two days, along with nausea and diarrhea. Blood pressure was , d+[DATE]. Resident became increasingly short of breath during the assessment. The resident was returned to her room and transferred to ed via sit to stand lift. The resident became incontinent of bowels while standing. The resident had increase fatigue this day. Review of the medication administration record (MAR) dated [DATE] revealed the resident's morning anti-hypertensive medications Lisinopril and Propranolol were held for a systolic blood pressure less than 100. The resident's blood pressure was documented to be ,d+[DATE] (hypotensive). Review of a Health Status Note dated [DATE] at 10:23 A.M. was entered by the Director of Nursing revealed Resident #27 appeared short of breath at rest in therapy room. She was not moving, respirations at 24. Denies upper respiratory illness symptoms. Denies cough, headache, runny nose. Resident was tested for flu and COVID earlier this week and both were negative. Loose stools continue. Oral mucosa was dry, fluids encouraged and given to her. The resident was alert and oriented to person, place, time, and situation, short of breath with speaking. Lungs clear throughout auscultation. Apical regular. Abdomen appeared distended and firm. Bowel sounds were sluggish in four quadrants. Resident has tremoring to hands and arms. Unable to obtain pulse oximetry value. Blood pressure ,d+[DATE] electric cuff, unable to auscultate top systolic number on manual blood pressure read by two nurses. Resident complained of weakness. Daughter and physician notified. Review of the EMR revealed Resident #27 was transported to the hospital on [DATE] at 11:45 A.M. and admitted with acute kidney injury. The resident did not return to the facility following the admission to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the emergency room documentation dated [DATE] revealed the resident was administered an aerosol treatment in route to the hospital for increased respirations and wheezing. The resident reported abdominal pain for the past two to three days in bilateral lower abdomen, squeezing sensation, increase bloating and distention, associated with diarrhea, one episode of emesis and overall weakness the past couple of days. A cat scan (CT) showed gaseous distended colon with minimal fluid levels likely diarrheal state, proctitis, enterocolitis, moderate distention of the bladder concerning for retention, bilateral hydronephrosis, right greater than left. The resident's white blood cell count was elevated at 21.4 concerning for infectious process. The resident's blood urea nitrogen (BUN) was elevated to 128 with a 4.0 creatinine, and 5.5 potassium (normal 3XXX,d+[DATE].0). Nephrology was consulted due to acute kidney injury, and they believed the resident's condition (abnormal laboratory testing) was due to dehydration. Lactic acid was 3.2 and resident received 3.3 liters of fluids. The resident was started on Doxycycline and Ceftriaxone antibiotics for possible pneumonia. A central line catheter and (urinary) Foley catheter were inserted in the emergency room . The resident was admitted to the intensive care unit (ICU) with diagnoses of sepsis, acute kidney injury, primary hypertension, hyperlipidemia, benign essential tremor, and atrial fibrillation. Diagnoses of dehydration, urinary retention and diarrhea were pertinent to the emergency room visit. Review of hospital records revealed Resident #27 had dark brown liquid, extremely foul-smelling stool, and scant urinary output on [DATE]. During hemodialysis on [DATE] via a temporary dialysis catheter, the resident converted to atrial fibrillation and the dialysis was stopped. On [DATE] laboratory testing showed worsened uremia. Blood cultures were negative, stool testing was negative for Clostridium Difficile (C-Diff) and positive for occult blood. On [DATE] the resident continued to have high volume stool output. The resident required vasopressin and norepinephrine to maintain her blood pressure. The resident was administered one unit of blood for a 5.7 hemoglobin that was obtained on [DATE] at 4:44 A.M. and remained in intensive care with shock and renal failure. Resident #27 passed away in the hospital on [DATE] at 3:56 P. M. with a preliminary cause of death documented as colitis. The resident's death certificate listed the causes of death as multiple organ failure, severe lactic acidemia requiring hemodialysis, acute kidney injury, and colitis. An interview on [DATE] at 5:51 P.M. with Resident #27's daughter revealed her mom complained of diarrhea on [DATE] and her speech was slurred. When she told the nurse, her solution was to put her to bed to rest. During the care conference on [DATE] she brought up the slurred speech and diarrhea. On [DATE], her mom told her they left her in an incontinence brief soiled for about an hour. She tried calling the nurse's station and the phone would act like it was picked up and then was disconnected. No one answered. She stated she called the Director of Nursing to have her go check on her around 9:00 A.M. She stated she then received a call from the facility that they were sending the resident to the hospital. She stated her mom was coherent but hallucinating at the hospital. An interview on [DATE] at 10:21 A.M. with Nurse Practitioner (NP) #131 revealed she visited the resident twice while the resident was in the facility. The NP stated the resident had no complaints of nausea, vomiting, diarrhea on [DATE] in the morning and this had been her last contact with the resident. The NP was aware the resident had chronic kidney disease and only one kidney. The NP stated if she had been aware/notified of the resident having diarrhea and not eating, she would have spoken to the physician and sent the resident to the emergency room or provided intravenous fluids. The NP verified a creatinine level of 4.0 and BUN of 128 reflected the resident was grossly dehydrated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Medical Director (MD) on [DATE] at 11:18 A.M. the MD shared course of treatment for a resident would clearly depend on how the resident was feeling as to what she would do. The MD stated she would want to determine if maybe the symptoms were a one-day stomach bug. The MD revealed medications such as Imodium (for diarrhea) and Phenergan (for nausea/vomiting) would be used to treat the symptoms and if symptoms persist, she would push fluids and watch the resident. The Medical Director verified the standing orders for Imodium and Phenergan could be administered to a resident without calling her. The MD revealed if a resident continued symptoms into a second day, she would expect to be notified. If the resident was progressively worse, she would send the resident to the hospital. Symptomatic management included to try to push fluids and watch. During the interview, the MD verified a creatinine level of 4.0 and BUN of 128 were indicative of dehydration. An interview on [DATE] at 4:53 P.M. with Licensed Practical Nurse (LPN) #82 revealed she worked day shift on [DATE] and [DATE]. On [DATE], Resident #27 was sick, and they did a flu and COVID test. She listened to the resident's bowel sounds. She stated the aides had reported the resident was not feeling well and having emesis and diarrhea. The LPN was unable to state why she did not administer any Phenergan or Imodium to the resident during this time. She was aware they were on the standing orders and stated she had initiated them in the past for other residents. The LPN revealed when she got the automatic alert on the EMR she would know the resident had eaten half of two meals or less, but stated she was unaware the resident had consumed none of the meals during this time. On [DATE] the LPN stated she was passing medications that morning and one of the physical therapy assistants came and asked her to assess Resident #27. The LPN stated she went to the therapy room. Resident #27 was short of breath, having a hard time in therapy and she really couldn't talk. The resident looked bad, and she stated she was shocked the resident was in there in that condition. The LPN revealed she didn't remember anyone saying the resident had diarrhea that morning. The LPN stated after assessing the resident she went and got the Director of Nursing (DON). An interview on [DATE] at 5:15 P.M. with Registered Nurse (RN) #80 revealed she had cared for Resident #27 during her stay, was doing the resident's knee dressing, and she asked her how she was doing. The resident reported she was having diarrhea, and the RN told the resident she would let the physician know. The RN stated sent a secure message via Point Click Care (PCC) EMR to the physician on [DATE] at 10:30 A.M. to notify her the resident was having diarrhea and an upset stomach. An order for Imodium was obtained at 11:06 A.M. when the physician replied. An interview on [DATE] at 5:45 P.M. with RN #84 revealed she received an alert if a resident eats 50 % or less two or more meals that day. In regard to Resident #27, the RN revealed she was unaware the resident had consumed no meals (lunch and supper) during the resident's stay. An interview on [DATE] at 5:52 P.M. with Certified Nursing Assistant (CNA) #70 revealed she could not remember Resident #27. An interview on [DATE] at 10:18 A.M. with CNA #65 revealed she worked [DATE] and had provided care to Resident #27. The CNA revealed the resident had diarrhea and she assisted the resident to get cleaned up and dressed before going to therapy on this date. The CNA revealed she had Certified Occupational Therapy Assistant (COTA) #130 come to the resident's room so the COTA could work with getting the resident out of bed with a walker. The CNA was aware the resident was transferred to the hospital later on this date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:21 P.M. a follow up interview with the Medical Director (MD) revealed she had reviewed Resident #27's medical record. The MD revealed it was less than 48 hours from the first lunch the resident missed until she was transferred to the hospital. She stated the first day a resident has a change, sometimes we do not give anything. The second day she only had one bowel movement documented so the staff or resident may not have thought the Imodium was needed. The resident may or may not have needed it. The MD could not answer whether the administration of medication for nausea would have prevented the resident's low meal intake. The MD verified she was not notified of the five meals marked as zero (not eaten). The MD also verified she had not personally assessed the resident during her stay in the facility. She stated she visited resident's on Fridays and stated Resident #27 must have arrived after she left. The MD revealed she would have been aware of the resident's kidney function from the NP. She would have expected the resident's creatinine to be around 2.0 (elevated) when she went to the emergency room and stated possible urinary retention could affect renal function. She also indicated a white blood cell count of 21 and an infection somewhere could affect kidney function. The MD felt there were contributing factors not just the nausea, vomiting, diarrhea that affected the resident's overall condition. The MD revealed, in hindsight, if she did know what was going to happen with the resident, she would have done something more. She verified the staff could have administered Imodium or Phenergan at any time but stated she could not answer if this would have made a difference (in the outcome to the resident). Interviews on [DATE] between 2:39 P.M. and 3:24 P.M. with COTA #130 and CNA's #67, #69 and #73 revealed they could not remember Resident #27. An interview on [DATE] at 3:34 P.M. with Physical Therapy Assistant (PTA) #129 revealed Resident #27 had increased fatigue due to activity. PTA #129 revealed she was present at the resident's care conference meeting that was held in the resident's room. The resident was in bed because she had diarrhea when she moved. PTA #129 stated she discussed the concerns from the care conference with RN #80 in her office following the conference. Review of facilities Notification of Change in Resident Condition Policy dated [DATE] revealed to promptly notify the attending physician of changes in resident's medical condition. This deficiency represents non-compliance investigated under Complaint Number OH00160184.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to identify measurable parameters for the use of as needed pain medications to ensure residents were free from unnecessary medication. This affected three (Resident's #5, #9 and #27) of three residents reviewed for unnecessary medications. The census was 26. Findings include: 1. Review of Resident #27's closed medical record revealed a 10/25/24 admission for skilled rehabilitative services following a hospitalization for a right total knee replacement that was performed on 10/23/24. Resident #27 had diagnoses including chronic kidney disease (CKD) Stage 3 (moderate to severe kidney damage), encounter for orthopedic aftercare right knee replacement, vertigo, hypertension, gout, hyperlipidemia, Vitamin D deficiency, obesity, restless leg syndrome, major depressive disorder, unilateral primary osteoarthritis of the right knee, tremor, anxiety disorders and a personal history of a pulmonary embolism. Review of Resident #27's admission physician's orders included orders for Acetaminophen Tablet give 650 milligrams (mg) by mouth every four hours as needed for mild pain (may give (2) two tablets to equal 650 mg every four hours) as needed, Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), narcotic, one tablet by mouth every four hours as needed for pain - moderate related to encounter for orthopedic aftercare AND give two tablets by mouth every four hours as needed for pain - severe related to encounter for orthopedic aftercare. Review of Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed Resident #27 as independent for decision making and no cognitive deficits with a 15 out of 15 BIMS score. The resident was administered opioids. Review of the Medication Administration Record revealed Acetaminophen Tablet give 650 (mg) as needed for mild pain was administered on 10/31/24 for a pain level of five. Oxycodone HCl Oral Tablet 5 mg one tablet by mouth every four hours as needed for moderate pain was administered 10/25/24 for a pain level of four, 10/26/24 for a pain level of six, 10/27/24 for a pain level of five, 10/28/24 for a pain level of eight, and 10/29/24 for a pain level of five twice. Oxycodone HCl Oral Tablet 5 mg two tablets by mouth every four hours as needed for severe pain was administered 10/2724 for a pain level of five, 10/28/24 for a pain level of five, and 10/30/24 for a pain level of eight. Acetaminophen 650 mg, Oxycodone 5 mg and 10 mg were all administered for a pain level of five. Interview 12/19/24 at 4:09 P.M. with Registered Nurse #121 verified Resident #27 did not have defined parameters as to what pain level was mild, moderate and severe. Nursing judgement, non verbal's and resident request was to be utilized. Verified nursing judgement was objective leading to inconsistency with the strength of pain medication based on the same pain rating. Review of the facility's Pain Management policy reviewed 11/07/24 indicated to ask the resident to rate the intensity of pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident. The policy did not indicate what numerical value would equal mild, moderate or severe pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Review of Resident #5's medical record revealed an 11/20/24 admission with diagnoses including fractured right femur, moderate protein calorie malnutrition, heart failure, asthma, acute cholecystitis, hypertension, hyperlipidemia, atherosclerotic heart disease, paroxysmal atrial fibrillation, anemia, and gastroesophageal heart disease. Physician orders included 11/20/24 Acetaminophen Tablet give 650 milligrams (mg) by mouth every four hours as needed for mild pain (may give (2) two tablets to equal 650 mg every four hours) as needed not to exceed 3000 mg and Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), narcotic, one tablet by mouth every four hours as needed for pain related to fracture of right femur subsequent encounter for closed fracture . Review of the 11/27/24 Admission Minimum Data Set Assessment revealed Resident #5 was independent for daily decision making, had an active diagnosis of heart failure and received opioid medication. Review of Resident #5's Medication Administration Record revealed Acetaminophen Tablet give 650 (mg) as needed for mild pain was administered on 11/21/24 for a pain level of five, 11/22/24 for a pain level of two, 11/24/24 for pain levels of three times two, 11/25/24 for pain levels of five and six, and 12/01/24 for a pain level of seven. Oxycodone HCl Oral Tablet 5 mg one tablet by mouth every four hours as needed for pain was administered 11/21/24 for a pain level of six, 11/22/24 for pain levels of three and seven, 11/23/24 for a pain level of eight times two, 11/24/24 for a pain level of eight, 11/25/24 for a pain levels of one and seven, 11/26/24 for a pain level of two, 11/27/24 for pain levels of one and six, 11/28/14 for pain levels of seven and eight, 11/29/24 for pain levels of six and seven, 11/30/24 for a pain level of two and 12/01/24 for a pain level of two. Interview 12/20/24 at 5:32 P.M. with the Director of Nursing verified Resident #5 did not have parameters for as to what was mild pain for the administration of acetaminophen and when to administer the narcotic. DON verified acetaminophen was administered for pain levels of two through seven and Oxycodone was administered for pain levels of one through eight making the type of pain medication administered for each pain level inconsistent. Review of the facility's Pain Management policy reviewed 11/07/24 indicated to ask the resident to rate the intensity of pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident. The policy did not indicate what numerical value would equal mild, moderate or severe pain. 3. Review of Resident #9 revealed a 10/30/24 admission with diagnoses including fracture left femur, fibromyalgia, atrial fibrillation, type 2 diabetes, hypertension, hyperlipidemia, polymyalgia rheumatica, anemia, osteoporosis and migraines. Physician orders included 10/30/24 Acetaminophen Tablet give 650 milligrams (mg) by mouth every four hours as needed for mild pain (may give (2) two tablets to equal 650 mg every four hours) as needed not to exceed 3000 mg daily, Methocarbamol OralTablet 500 MG (Methocarbamol) one tablet every six hours as needed for moderate pain, and Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), narcotic, one tablet by mouth every four hours as needed for severe pain related to fracture neck of left femur initial encounter for closed fracture for seven days. Ultram 50 mg was ordered every six hours as needed for pain on 11/14/24. On 11/20/24 the Ultram order was changed to 50 mg every six hours as needed for mild to moderate pain. There were no parameters identified for mild, moderate and severe pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366453	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Poland	301 West Western Reserve Road Poland, OH 44514

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the 11/06/24 Admission Minimum Data Set Assessment revealed Resident #9 was independent for daily decision making, and received opioid medication. Review of Resident #9's Medication Administration Record revealed there were 45 doses in November and one dose administered in December of Methocarbamol OralTablet 500 mg (Methocarbamol) one tablet every six hours as needed for moderate pain without a pain level identified. Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), narcotic, one tablet by mouth every four hours as needed for severe pain related to fracture neck of left femur initial encounter for closed fracture for seven days included 16 doses were administered in November for pain levels of zero to nine. Acetaminophen Tablet give 650 (mg) as needed for mild pain was administered 29 times in November for pain levels ranging from one to seven and seven times in December for pain levels ranging from one to five. Ultram 50 mg one tablet every six hours as needed was administered 46 times in November for pain levels ranging from one to 10 and 55 doses in December for pain levels ranging from one to nine. Interview 12/20/24 at 5:51 P.M. with the Director of Nursing verified Resident #9 did not have parameters as to what was mild, moderate and severe pain was for the administration of acetaminophen, Methocarbamol or the narcotics Ultram or oxycodone. DON verified Methocarbamol was administered without documented pain levels. DON verified acetaminophen was administered for pain levels of one through seven while narcotics were administered for pain levels of zero to ten making the expected relief inconsistent. Narcotics were administered as needed when there was zero pain indicated. Review of the facility's Pain Management policy reviewed 11/07/24 indicated to ask the resident to rate the intensity of pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident. The policy did not indicate what numerical value would equal mild, moderate or severe pain. This deficiency represents non-compliance investigated under Complaint Number OH00160184.