STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365732	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austintown Healthcare Center	650 S Meridian Road Youngstown, OH 44509

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and hospice record review, and facility policy review, the facility failed to maintain accurate and consistent wound documentation for a resident receiving hospice services. The facilities wound measurements and staging differed from the hospice nurse's documentation. This inconsistency resulted in incomplete and inaccurate medical records. This affected one resident (#681) of three resident records reviewed for wound care. The facility census was 82. Findings include:Review of the closed medical record revealed Resident #681 was admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, vascular dementia with behavioral disturbance, mild protein-calorie malnutrition, peripheral vascular disease, vitamin b12 deficiency anemia, dysphagia, functional quadriplegia, personal history of transient ischemic attack (TIA), cerebral infraction without residual deficits, and anxiety disorder. Resident #681 was admitted for respite care and was discharged home on [DATE]. Review of the admission evaluation completed on 07/07/25 at 10:08 A.M. authored by Registered Nurse (RN) #1000 revealed Resident #681 was dependent on two or more staff with all activities of daily living. She was incontinent of bowel and bladder, had diminished safety awareness, and required a Hoyer (mechanical) lift for transfers. She had a red non-blanchable area to the right outer ankle. Review of the admission skin assessment dated [DATE] at 10:38 A.M. authored by RN #1006 revealed Resident #681 had a dark red/maroon area noted to the right ankle that was a suspected deep tissue injury (SDTI). A SDTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Skin-prep (creates a protective, film-like barrier on the skin) and foam dressing were applied. No other impairment was noted upon assessment. Review of the admission physician orders for July 2025 revealed weekly skin assessments, a pressure reducing/relieving mattress every shift for pressure reducing/relieving, Hospice provider RN or Home Health Agency (HHA) visit per Hospice schedule through Grace Hospice, pain level every shift, wound care orders to apply Skin-prep to right ankle and cover with foam dressing daily and as needed (PRN), if dressing becomes soiled or dislodged and every shift for preventative. Review of the admission skin assessment completed by RN #1006 and Wound (NP) #1007 dated 07/08/25 10:38 A.M. revealed Resident #681 had a SDTI to the right ankle. Treatment was to apply Skin-prep with a foam dressing daily and as needed (PRN). No other skin impairment noted. Skin was warm and dry, thin, fragile, intact, no open wound, ecchymosis, non-blanchable erythema to the right ankle measuring 2.0 centimeters (cm) in length by 2.0 cm in width by 0 cm in depth. The peri-wound was intact and fragile with erythema. There was zero percent (%) eschar, zero % granulation, zero % slough, 100% epithelial tissue. The area was described as a Stage I pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence). The treatment plan was to cleanse with normal saline, apply Skin-prep to the base of the wound, secure with bordered foam gauze, and change three times weekly and PRN. Preventative measures included: recommend head of bed limited to 30 degrees or less as tolerated unless contraindicated, float heels while in bed with use of heel boots, apply moisturizer to resident's skin routinely, do not massage over bony prominences, minimize friction and shear by using an approved material to assist with positioning up in bed, continue with turning and repositioning schedule per protocol for pressure prevention, recommend resident out of bed as tolerated for limited intervals of time, alternating activity to minimize pressure, use pillows for positioning to prevent pressure to bony prominences. New recommendations: The resident has a treatment change listed above. Please reference the recommended orders for updated treatments. The resident is currently under hospice services. Goals of care remain to minimize pain and risk of infection. Continue palliative wound management. The risk of complications and/or morbidity/mortality of the patient's management is moderate. Review of the hospice notes dated 07/12/25 authored by Hospice RN #1008 revealed wound care was performed to the unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) to Resident #681's right lateral ankle. The wound measured 1.5 cm by 1.5 cm with 0-25% necrotic tissue slough and 76-100% eschar. The wound was cleansed with wound cleanser, covered with a dry dressing, instructed caregiver/facility staff in wound care. RN #1000 will be notified of new wound and wound care orders. RN #1000 instructed to call hospice for questions, concerns, or change in status. Review of the progress note