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	03/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation and facility policy review, the facility failed to ensure Resident #3 had a fitted sheet placed on his bed. This affected one resident (#3) of six residents reviewed for clean, comfortable, homelike environment. The facility census was 87.Findings include:Review of Resident #3 's medical record revealed an admission date of 04/09/22 with diagnoses of fluid overload, localized edema, acute posthemorrhagic anemia, gastrointestinal hemorrhage, acute respiratory failure with hypoxia, epilepsy, not intractable, with status epilepticus, type II diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease, morbid (severe) obesity due to excess calorie, bipolar disorder, current episode mixed, adjustment disorder with mixed disturbance of emotions and conduct, chronic venous hypertension (idiopathic) with inflammation of bilateral lower extremity, mild cognitive impairment of uncertain or unknown etiology, diabetic neuropathy, intermittent explosive disorder, personal history of COVID-19, hyperlipidemia, lack of expected normal physiological development in childhood, cognitive communication deficit, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic sinusitis, atrial fibrillation, long term (current) use of insulin, gout, difficulty in walking, muscle weakness (generalized), and need for assistance with personal care.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was alert and oriented and cognitively intact. Resident #3 had impairment on both sides of upper and lower extremities in functional limitation of range of motion and was at risk for skin breakdowns.Observation on 03/23/26 at 11:13 A.M. revealed Resident #3 had no fitted sheet on his bed.Interview on 03/23/26 at 11:14 A.M. with Resident #3 revealed he rarely had a fitted sheet on his bed, the facility doesn't have fitted sheets to fit this size bed (bariatric bed). Interview on 03/23/26 at 11:13 A.M. with Housekeeping Director #250 confirmed no fitted sheet was on Resident #3 bed, and the facility does have issues getting fitted sheets to fit the bariatric bed. The facility usually uses flat sheets.Interview on 03/23/26 at 11:17 A.M. with Assistant Director of Nursing (ADON) #294 confirmed Resident #3 did not have a fitted sheet on his bed, and Resident #3 was lying on the bare mattress.Review of the undated, Resident Rights policy the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents.This deficiency represents non-compliance identified under Complaint Number 2655564.

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
	365732	A. Building B. Wing	03/26/2026

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Austintown Healthcare Center	650 S Meridian Road Youngstown, OH 44509

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and facility policy review, the facility failed to report Resident #101's allegations of staff-to-abuse to the State agency. This finding affected one (Resident #101) of three residents reviewed for abuse. This facility census was 87.Findings include:Review of Resident #101's medical record revealed the resident was admitted on [DATE] and discharged on 02/18/26 with diagnoses including wedge compression fracture of the T7-T8 vertebra, repeated falls and bipolar disorder.Review of Resident #101's Witness Statement dated 12/22/25 revealed Curricular Practical Training Registered Nurse (CPT RN) #277 went into the resident's room to administer the morning medications, and the resident was seen trying to sit up by himself in bed. He asked the nurse to help him sit up, the nurse tried to help him sit up, and the resident became combative and abusive. The nurse told him she was sorry and they had only tried to pull him up as he asked for help.Review of Resident #101's Witness Statement dated 12/22/25 authored by Certified Nursing Assistant (CNA) #296 revealed the staff member observed the resident and nurse during medication pass and the resident was lying down. The resident asked for assistance, and the nurse assisted by holding wrists and assisting him to sit up. The resident became agitated and she stopped. The resident can be very combative and argumentative. The resident did not like the nurse and the new staff.Review of Resident #101's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Interview on 03/23/26 at 10:07 A.M. with the Director of Nursing (DON) revealed Resident #101 had problems with the Nigerian nursing staff and one staff member specifically (CPT RN Intern #277). Interview on 03/23/26 at 11:00 A.M. with the Administrator revealed Resident #101 did not report abuse. The Administrator indicated CPT RN Intern #277 pulled his hands to help him up and he felt it hurt his back. The Administrator confirmed the facility did not file an abuse Self-Reported Incident (SRI) with the State agency.Telephone interview on 03/23/26 at 11:54 A.M. with CPT RN Intern #277 indicated she walked into Resident #101's room to administer the resident's medications, and the resident was lying on his back. CPT RN Intern #277 felt the resident would choke on the medications and asked the resident to sit up. She stated the resident put his hands out and the nurse placed her hands in his and let him use her to move his body around to sit up. She denied pulling the resident by his hands at any point. CPT RN Intern #277 indicated the resident had reported she hurt him and she denied the allegation.Telephone interview on 03/24/26 at 10:17 A.M. with Ombudsman #298 revealed she called the Administrator on 12/29/25 and reported that Resident #101 had alleged physical abuse against one of the nursing staff. Ombudsman #298 indicated the Administrator did not file an SRI on behalf of Resident #101.Review of the undated Ohio Abuse, Neglect and Misappropriation policy revealed alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported no later than two hours after an allegation involving abuse and/or serious bodily injury. For alleged violations of neglect, exploitation, misappropriation of resident property, or mistreatment that do not result in serious bodily injury, the facility must report the allegation no later than 24 hours. The self-report will be made by the administration to the State Survey Agency and other local authorities including but not limited to, the local police if appropriate.This deficiency represents non-compliance investigated under Complaint Number 2696067.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to provide a resident room that was in good repair for one (Resident #39) of six residents reviewed for physical environment. The facility census was 87.Findings include:A review of medical records for Resident #39 revealed an admission date of 09/24/25. Significant diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations, and altered mental status.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) with a score of three out of 15, indicating Resident #39 had severe cognitive impairment.Review of the care plan dated 01/13/26 revealed no indications for Resident #39 refused housekeeping and maintenance services.An observation on 03/23/26 at 1:59 P.M. revealed the room for Resident #39 was in general disrepair. The chair rail had splintered wood. Observation on 03/24/26 at 10:01 A.M. revealed the resident's bed was in a low position horizontal to wall with the splintered wood approximately four feet long on the chair rail.Interview with Director of Plant Maintenance #267 on 03/24/26 at 10:06 A.M. confirmed the chair rail was in disrepair and needed replacement at the time of the observation.Review of undated Resident Rights policy revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care.This deficiency represents non-compliance investigated under Complaint Number 2655564.