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	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, record review, and facility policy review the facility failed to ensure Resident #78's immediate care and service needs were assessed and orders initiated at the time of admission. This affected one resident (#78) of two residents reviewed for admissions. In addition, the facility failed to ensure Resident #55 received wound treatments according to physician orders. This affected one resident (#55) of four residents reviewed for wound treatments. The facility census was 80. Finding included: 1. Review of the closed medical record for Resident #78 revealed an admission date of 03/08/25 at 6:07 P. M. and a discharge from the facility per resident request on 03/10/25 at 12:45 P.M Diagnoses included local infection of the skin, subcutaneous tissues, non-pressure ulcer of the right and left lower legs with fat layer exposed, peripheral vascular disease, type II diabetes, hypertension, Chronic Obstructive Pulmonary Disorder (COPD), and major depressive disorder. Review of Resident #78's progress notes dated 03/08/25 to 3/10/25 revealed there was no evidence of an admission note to the facility, no evidence the physician was notified of arrival and no evidence the admitting staff verified admission orders with the physician. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #78's Hospital After Visit Summary (AVS) dated 03/08/25 revealed Resident #78 had been hospitalized from [DATE] to 03/08/25 with a diagnosis of foot infection. Resident #78 was discharged from the hospital with the following medication orders: Daptomycin (antibiotic) 800 milligram (mg) Intravenously (IV) every 24 hours for 14 days (next dose due to be given on 03/09/25), Oxycodone-acetaminophen (narcotic pain medication) 5-325 mg one tablet daily as needed for pain for three days (last dose given on 03/08/25 at 9:56 A.M.), Humulin (insulin to treat diabetes) R U-500 Kwik Pen 500 Unit/milliliter (ml) inject 120 units with breakfast, 50 units with lunch and 120 units with dinner (last dose given on 03/08/25 at 11:50 A.M.), albuterol sulfate 108 microgram (mcg)/Actuation (act), inhale two puffs into lungs every six hours as needed, apixaban (blood thinner) 5 mg take one tablet by mouth once a day starting on 03/09/25, bumetanide (diuretic) one mg tablet by mouth every day in the morning, citalopram (antidepressant) 20 mg tablet take one tablet daily (last dose given on 03/08/25 at 9:51 A.M., lisinopril (high blood pressure treatment) 10 mg tablet daily (last dose given on 03/08/25 at 9:51 A.M.), metoprolol (blood pressure treatment) 100 mg tablet by mouth daily (last dose given on 03/08/25 at 9:51 A.M.), mometasone-formoterol 200-5 mcg/act inhale 2 puffs in the morning and in the evening, Mujaro 2.5 mg once a week, multivitamin with minerals one tablet by mouth daily, pregabalin (anti-convulsant) 300 mg capsule by mouth twice a day for convulsions twice a day (last dose given on 03/08/25 at 9:51 A.M.), tamsulosin 0.4 mg take two capsules daily to equal 0.8 mg (last dose given on 03/08/25 at 9:51 A.M.) . There were also orders for wound care treatments to the bilateral lower extremities, rehabilitation therapy order and infectious disease protocol for IV therapy including standing orders for laboratory work, IV flushing orders, and IV dressing change orders. Review of Resident #78's physician orders revealed it was not until 03/10/25 that the following were initiated as orders: all facility standing orders for monitoring oxygen saturation and documenting results every shift due to COPD, Physical Therapy (PT) eval, Occupational Therapy (OT) eval, height, weight times four weeks upon admission, vital signs every shift times 72 hours then daily, COVID-19 testing as needed/may use PCR or POC testing, weekly skin assessment to be completed and documented, read tuberculosis (TB) skin test number one and number two with documentation of results on Medication Administration Record (MAR), ensure the resident is on a pressure reducing/relieving mattress every shift, consults with Audiology, Dental, Optometry, Ophthalmology and/or Podiatry as needed, monitor for pain every shift, and a wound care consult. Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated March 2025 confirmed the aforementioned orders were not initiated until 03/10/25. Further review of Resident #78's physician orders revealed medications were not reconciled at the time of admission and the following orders were not initiated until 03/09/25: Daptomycin 500 mg IV, Oxycodone 5-325 mg, bumetanide 1 mg, metoprolol 100 mg, albuterol 108 mcg/act, tamsulosin 0.4 mg give two capsules to equal 0.8 mg, Mounjaro 2.5 mg/0.5 ml injection, pregabalin 300 mg two times a day for convulsions, and citalopram 20 mg for depression. Further review of Resident #78's Medication Administration Record (MAR) dated March 2025 confirmed Daptomycin, Oxycodone, bumetanide, metoprolol, albuterol, tamsulosin, Mounjaro, pregabalin and citalopram were not initiated until 03/09/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/25 at 4:03 P.M. with the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN) #631 was the admitting nurse for Resident #78 and did not complete any of the admission assessments required for new admissions, nor did they initiate any of the admitting physician orders from the hospital. Interview on 06/11/25 at 9:23 A.M. with the DON revealed they confirmed on admission, nursing staff were to complete a medication reconciliation, implement all orders obtained from the hospital, and notify the physician of resident arrival. The DON confirmed admission orders for Resident #78 were not initiated on the day of admission of 03/08/25 and were completed between 03/09/25 and 03/10/25 by Registered Nurse (RN) #712 causing medications, treatments and assessments to be missed for Resident #78. The DON also confirmed LPN #631 was issued an Employee Corrective Action final written warning for Performance/Policy Violation and Safety/Carelessness, due to: the staff member failing to comply with the admission policy of initial assessment and order entry in a timely manner of first hour of admission, interfering with medication delivery for treatment, initial assessment of wound and IV site not completed, and no orders for care entered. No admit vital signs were obtained, or height and weight. admission was not touched by shift change. This occurrence led to delay in medications and treatments being administered. Review of the undated facility policy titled admission Evaluation, revealed it was the policy of the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center. Under the Procedure section staff are to complete the admission Initial UDA and appropriately triggered assessments electronically as soon as feasible but within 24 hours. Second, staff were to prioritize resident needs with appropriate interventions to include but not limited to, meeting immediate physical needs including assessment of pain, provide social and emotional support, identify any culturally specific needs, consider elopement risk, consider pressure injury risk, provide toileting needs, complete medication reconciliation, and consider last meal eaten and provide hydration. 2. Review of the medical record for Resident #55 revealed an admission date of 02/01/24 with diagnoses including chronic embolism and thrombosis of right and left femoral veins (blood clots to the legs), varicose veins of the left lower extremity with ulcer, peripheral vascular disease (PVD) (disorder that restricts the blood flow to the arms, legs and other parts of the body) and diabetes mellitus. Review of the physician's orders for June 2025 revealed Resident #55 had an order to cleanse the wound to his right posterior lower leg with normal saline and apply collagen (wound treatment) particles, cover with xeroform (non-adhering wound dressing), pad and wrap with kerlex (gauze wrap) daily and as needed dated 06/05/25. There were no physician's orders for wound care to the left leg. Review of treatment administration record (TAR) for June 2025 for Resident #55 revealed the nursing staff had documented on 06/08/25 that his treatment to his right lower leg was completed. There were no orders for wound treatments to the left leg. Review of the nursing progress notes from 06/07/25 through 06/09/25 for Resident #55 revealed there was no documentation related to his left lower leg having an open area, the physician being updated or a treatment being ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/09/25 at 1:43 P.M. of Resident #55 revealed he had wound treatments to bilateral lower legs. The dressings were dated 06/07/25. Observation and interview on 06/09/25 at 1:45 P.M. with Licensed Practical Nurse (LPN) #600 verified Resident #55 had a venous ulcer to the back of his right lower leg. She stated his treatment should have been completed daily and was not done on 06/08/25 as ordered. LPN #600 stated she did not know why he had a dressing on the left lower leg. She verified the dressings to bilateral lower extremities were dated 06/07/25. Resident #55 stated nursing staff had not performed the treatment to his right lower leg on 06/08/25. Interview and observation on 06/09/25 at 1:53 P.M. with Registered Nurse (RN) #609 revealed the dressing to the right lower leg was adaptic (non-adhering wound dressing) with a dry dressing and rolled gauze to secure the treatment in place. RN #609 stated Resident #55 previously had scabs to the front of his left leg due to his PVD. Observation revealed an open area to the front of his left leg. RN #609 stated the scabs must have come off and the nurse placed a dressing. She verified she was not updated on the resident's open area to his left leg. Interview on 06/09/25 at 1:59 P.M. with LPN #600 verified her initials were on the TAR on 06/07/25 and she had placed the dressing on Resident #55's left lower leg. She stated she placed the same treatment that was on the right lower extremity. LPN #600 stated she had not updated the physician, received an order for the left lower extremity or documented in the resident's medical record. Review of the facility policy titled, Skin Care and Wound Management Overview, undated, revealed the facility should review and select the appropriate treatment, obtain a physician's order and document treatment in the treatment administration record. This violation represents non-compliance investigated under Master Complaint Number OH00164793 and Complaint Number OH00163639.

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	365732	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for 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, interview, record review and review of facility policy, the facility did not ensure wound assessments accurately identified date of onset of a pressure ulcer and wound treatments were implemented as ordered by the physician for Resident #77. This affected one resident (Resident #77) of four residents reviewed for pressure ulcers. The facility census was 80. Findings include: Review of the closed medical record for Resident #77 revealed an admission date of 12/13/24 with diagnoses including osteomyelitis (infection of the bone) of the left foot and ankle, peripheral vascular disease (disorder that restricts the blood flow to the arms, legs and other parts of the body) and cellulitis (skin infection where the skin is swollen, painful and warm to the touch). Review of the hospital After Visit Summary, dated 12/13/24, revealed at the time of discharge from the hospital, Resident #77 had no pressure ulcers, but did have treatments in place for surgical incisions to his femoral left leg, left leg and left toe. Review of the nursing admission evaluation dated 12/13/24 for Resident #77 revealed he had no pressure ulcers. It was noted he had surgical incisions to the groin, left thigh, left lower leg and left toes. Review of the nursing notes for Resident #77 dated from 12/13/24 through 12/16/24 revealed the nursing staff had not documented any information to identify a pressure ulcer on right buttocks. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #77 revealed he had one Stage III pressure ulcer that was present upon admission. Review of the care plan for Resident #77, dated initiated 12/27/24 revealed he was admitted to the facility with a stage III pressure ulcer to his right buttock. Interventions included administer medications and treatments as ordered by medical provider, apply barrier creams post incontinence episodes, complete weekly skin checks and daily wound assessments. Review of the Wound Assessment Report, dated 12/17/24 by Nurse Practitioner (NP) #714 revealed she saw Resident #77 for the first time for a Stage III pressure ulcer (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) to the right buttocks. NP #714 stated it was 5.0 centimeters (cm) in length, 1.0 cm in width and 0.10 cm in depth and was present on admission. She ordered the facility nursing staff to cleanse the right buttock with normal saline, apply Triad Cream (wound care product designed to treat and protect skin from damage due to pressure ulcers) and leave open to air twice daily and as needed. Review of the Wound Assessment Report, dated 12/26/24 by NP #714 revealed she saw Resident #77 again for his right buttocks Stage III pressure ulcer. NP #714 stated the wound was now 4.0 cm in length, 2.0 cm in width and .2 cm in depth. NP #714 provided a new order for the nursing staff to cleanse the right buttock with normal saline and apply Triad Cream and a bordered foam daily and as needed. (continued on next page)

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	365732	A. Building B. Wing	06/12/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders and treatment administration record from December 2024, revealed NP #714's orders were not implemented for Resident #77's pressure ulcer of the right buttocks until 12/26/24. Interview on 06/11/25 at 2:37 P.M. with Registered Nurse (RN) #609 revealed she rounded with NP #714 and saw Resident #77 on 12/17/24. She verified NP #714 provided an order for treatment to Resident #77's right buttocks Stage III pressure ulcer. RN #609 stated NP #714 entered her own treatment orders in the computer and must have missed putting Resident #77's order in for his right buttocks. RN #714 verified that prior to NP #714 initially seeing Resident #77's right buttock pressure ulcer on 12/17/24 there had been no skin assessment nor other documentation in the medical record to reflect Resident #77 had a pressure ulcer upon admission yet it was documented as present upon admission in the MDS and wound assessment report. Interview on 06/12/25 at 11:28 A.M. with NP #714 verified she assessed Resident #77 on 12/17/25 and provided an order for Triad Cream to his right buttocks. She stated she had forgot to enter his order for the Stage III pressure ulcer into the computer until she returned again on 12/26/24. She stated his wound mildly worsened, however, due to his medical condition worsening could be expected as unavoidable and it was not due to the lack of treatment with the Triad Cream from 12/17/24 to 12/25/24. NP #714 stated she was notified Resident #77 was admitted with the pressure ulcer and she assessed him four days later. Review of the facility policy titled, Skin Care and Wound Management Overview, undated, revealed the facility should review and select the appropriate treatment, obtain a physician's order and document treatment in the treatment administration record. This violation represents non-compliance investigated under Master Complaint Number OH00164793 and Complaint Number OH00163639.

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	365732	A. Building B. Wing	06/12/2025

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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. Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #184's enteral feedings were administered as ordered. This affected one resident (Resident #184) of two residents reviewed for enteral nutrition. The facility census was 80. Findings include: Review of the medical record for Resident #184 revealed an admission date of 05/23/25 with diagnoses including cerebral infarction (stroke), hemiplegia affecting right side (paralysis), dysphagia (difficulty swallowing) and cognitive communication deficit. Review of the physician's orders for June 2025 for Resident #184 revealed she had an order for enteral feedings every shift at 60 milliliters (mL) an hour for 20 hours via the pump dated 06/03/25. Review of the Medication Administration Record (MAR) for June 2025 for Resident #184 revealed Registered Nurse (RN) #625 signed off her enteral feed order on 06/09/25 prior to 10:47 A.M. as administered as ordered. Observation on 06/09/25 at 10:40 A.M. of Resident #184 revealed her enteral feeding was running at 50 mL per hour. Observation and interview on 06/09/25 at 10:52 A.M. with RN #625 verified Resident #184's enteral feeding was running at 50 mL per hour and should be at 60 mL per hour. Review of the facility policy titled, Enteral General Nutritional (tube feeding) Guidelines, undated, revealed feeding the enteral feed through the electronic pump, nursing staff should verify the practitioner's order including the volume and rate to be infused.

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	365732	A. Building B. Wing	06/12/2025

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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** Based on record review, interview and review of facility policy, the facility failed to ensure dialysis residents were monitored before and after dialysis treatments, and daily weights were obtained according to physician order for Resident #4. This affected one resident (Resident #4) out of two residents reviewed for dialysis. The facility census was 80. Findings include: Review of Resident #4's medical record revealed an admission date of 12/08/23. Diagnoses included end stage renal disease, dependence on renal dialysis, chronic diastolic congestive heart failure, hyperlipidemia, disorders of bone density, Gastro-Esophageal Reflux Disease (GERD), hypertensive heart and Chronic Kidney Disease (CKD), type II diabetes mellitus, anxiety, and major depressive disorder. Review of Resident #4's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition. They required setup or clean up assistance for eating, substantial to maximal assistance for oral hygiene, upper body dressing, personal hygiene, and bed mobility. They were dependent on staff for toileting hygiene, showers, and lower body dressing. Review of Resident #4's care plan date 10/05/24 revealed the resident was on dialysis therapy related to CKD three times a week. Interventions and goals indicated the resident would be free from signs and symptoms of complications from hemo-dialysis. Staff were to administer medications per medical provider's orders including monitoring weights daily and completing a pre and post dialysis assessment every dialysis treatment day. Review of Resident #4's physician orders dated June 2025 revealed there were orders for staff to obtain daily weights related to congestive heart failure and dependency on renal dialysis. There was an order for pre and post dialysis assessments to be completed every Tuesday, Thursday, and Saturday. Review of Resident #4's pre dialysis assessments revealed there were no pre dialysis assessments completed on 04/01/25, 04/03/25, 04/10/25, 04/15/25, 04/17/25, 04/22/25, 04/29/25, 05/01/25, 05/06/25, 05/13/25, 05/15/25, 05/20/25, and on 06/07/25. Review of Resident #4's post dialysis assessments revealed there were no post dialysis assessments completed on 04/15/28, 04/22/25, 04/29/25, 05/10/25, 05/15/25, 05/17/25, 05/29/25, and on 06/07/25. Review of Resident #4's daily weights from 04/01/25 through 06/05/25 revealed daily weights were not completed on 04/01/25, 04/02/25, 04/03/25, 04/06/25, 04/07/25, 04/09/25, 04/10/25, 04/14/25, 04/15/25, 04/16/25, 04/20/25, 04/21/25, 04/23/25, 04/24/25, 04/25/25, 04/27/25, 04/28/25, 04/30/25, 05/01/25, 05/04/25, 05/05/25, 05/06/25, 05/07/25, 05/08/25, 05/09/25, 05/10/25, 05/11/25, 05/12/25, 05/13/25, 05/14/25, 05/15/25, 05/16/25, 05/17/25, 05/18/25, 05/19/25, 05/21/25, 05/22/25, 05/26/25, 05/28/25, 05/29/25, 05/30/25, 06/01/25, 06/02/25, 06/03/25, 06/04/25, and on 06/05/25. (continued on next page)

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	365732	A. Building B. Wing	06/12/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/09/25 at 1:52 P.M. with Registered Nurse (RN) #610 revealed the Certified Nursing Assistants (CNA) obtain the resident's weight and notify the nurse of results so they can be documented. RN #610 stated there was no other place they would document the weights except for in the Electronic Medical Record (EMR) under the weight/vitals tab. Interview on 06/11/25 at 3:51 P.M. with Dietician #715 revealed they confirmed Resident #4 was on daily weights related to their diagnosis of congestive heart failure and the need for hemo-dialysis. Dietician #715 confirmed the daily weights are not being done per physician orders. Interview on 06/12/25 at 11:57 A.M. with the Regional Director of Clinical Operations (RDCO) revealed they confirmed there were multiple missing pre and post dialysis assessments for Resident #4 as well as multiple missing daily weights from 04/01/25 to 06/12/25 with no explanation given as to why. The RDCO stated staff are to complete a pre and post dialysis assessment on each dialysis day and the daily weights should be completed and documented daily per physician orders. Review of the undated facility policy titled Hemodialysis Care and Monitoring, revealed the facility uses this policy to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The facility is responsible to provide resident centered care to meet the resident's need for dialysis, provide a method for coordination and collaboration between the nursing home and the dialysis facility, provide outside dialysis services with an agreement between the facility and a Medicare Certified Dialysis facility, Provide a method for on-going communication and collaboration for the development and implementation of dialysis care plan. The facility will provide pre and post dialysis assessments and weights per physician orders.

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	365732	A. Building B. Wing	06/12/2025

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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. Based on record review and interview, the facility failed to ensure medications were obtained timely from the pharmacy to meet resident needs. This affected two residents (Resident #64 and #78) of eight residents reviewed for medication administration. The facility census was 80. Findings include: 1. Review of Resident #64's medical record revealed an admission date of 05/03/25 with diagnoses including local infection of the skin and subcutaneous tissue, cellulitis of Left Lower Extremity (LLE), displaced bicondylar fracture of left tibia, type II diabetes mellitus, hypertension, major depressive disorder, and acute embolism and thrombosis of deep vein of left lower extremity. Review of Resident #64's admission Minimum Data Set (MDS) 3.0 assessment revealed the resident had intact cognition, was independent with eating, required setup or clean up assistance with oral hygiene, partial to moderate assistance with upper dressing,, personal hygiene, and bed mobility. Resident #64 required substantial to maximal assistance with toileting hygiene and showers and was dependent on staff for lower body dressing. Review of the Medication Administration Record (MAR) for May 2025 for Resident #64 revealed nursing staff documented not administered/not available from the pharmacy on 05/03/25 for the following medications: Amlodipine 10 Milligrams (mg), Atorvastatin 40 mg for lipids daily, Colace 100 mg for constipation, Duloxetine 90 mg daily for depression, Hydrochlorothiazide (HCTZ) 12.5 mg for hypertension daily, Lisinopril 40 mg daily for hypertension, Oxybrutrin 5 mg daily for urinary health, protonix 40 mg daily for GERD, Pioglitazone 30 mg daily for diabetes, Synthroid 88 micrograms (mcg) daily for hypothyroidism, Vitamin D 50 mcg for supplement, metformin 500 twice a day for diabetes, and Ceftriaxone 2 gm IV daily for soft tissue infection. Interview on 06/11/25 at 10:01 A.M. with Resident #64 revealed her medications were not available to be administered to her on the date of admission to the facility. She stated she had to wait a day to a day and a half before all her medications were available to be administered. Resident #64 stated because she did not receive her medications, she just felt like laying in bed, not going to therapy and not taking a shower because she felt nauseated and had some pain. 2. Review of the closed medical record for Resident #78 revealed an admission date of 03/08/25 at 6:07 P. M. and discharged from the facility per resident request on 03/10/25 at 12:45 P.M Diagnoses included local infection of the skin, subcutaneous tissues, non-pressure ulcer of the right and left lower legs with fat layer exposed, peripheral vascular disease, type II diabetes, hypertension, Chronic Obstructive Pulmonary Disorder (COPD), and major depressive disorder. Review of Resident #78's MAR dated March 2025 revealed on 03/09/25 the resident did not receive their Citalopram 20 mg daily for depression, pregabalin 300 mg twice a day for convulsions, and Daptomycin 500 mg IV daily for infection due to not being available from the pharmacy. (continued on next page)

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	06/12/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 9:49 A.M. with Licensed Practical Nurse (LPN) #513 revealed LPN #513 did not always have the resident medications to give the residents because the medications were not being made available from the pharmacy and were not in the Nexus system (automated pill dispenser). LPN #513 stated they must make multiple phone calls to the pharmacy to inquire about where the medications are. LPN #513 stated with new admissions it is not uncommon if their medications are not available to give for approximately a day to a day and a half due to not arriving from the pharmacy in a timely manner. LPN #513 verified medications not administered as ordered for Resident #64 due to not being available to give to Resident #64. Interview on 06/11/25 at 9:23 A.M. with the DON verified Resident #78 had missed physician ordered medications due to the medications not being available to give to Resident #78. Interview on 06/11/25 at 1:02 P.M. with LPN #510 revealed there are times when medications do not arrive from the pharmacy timely. LPN #510 stated it can take up to a day and a half to get certain meds, including IV antibiotics and any medications not available in the Nexus system. Review of the facility policy titled, Pharmacy Services, revised 09/01/21, stated the pharmacy would supply medications that were needed and deliver the medications to the facility. This deficiency represents non-compliance investigated under Complaint Number OH00163639.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed when administering Intravenous (IV) medications for Resident #64. This affected one resident (Resident #64) out of three residents reviewed for Enhanced Barrier Precautions. The facility census was 80. Findings include: Review of Resident #64's medical record revealed an admission date of 05/03/25 with diagnosis including local infection of the skin and subcutaneous tissue, cellulitis of Left Lower Extremity (LLE), displaced bicondylar fracture of left tibia, type II diabetes mellitus, hypertension, major depressive disorder, and acute embolism and thrombosis of deep vein of left lower extremity. Review of Resident #64's admission Minimum Data Set (MDS) 3.0 assessment revealed the resident had intact cognition, was independent with eating, required setup or clean up assistance with oral hygiene, partial to moderate assistance with upper dressing, personal hygiene, and bed mobility. Resident #64 required substantial to maximal assistance with toileting hygiene and showers and was dependent on staff for lower body dressing. Review of Resident #64's care plan dated 05/21/25 revealed a care plan initiated related to Resident #64 had an infection, cellulitis of the LLE and was on IV antibiotics. Goals and interventions included the resident would be free from signs and symptoms of complications related to the infection. Staff were to administer antibiotics per medical providers orders, observe for side effects and effectiveness and report abnormal findings to medical provider. Additionally, there was a care plan for Enhanced Barrier Precautions (EBP) due to providing care to the resident with a history or colonized multi-drug-resistant organism. The care plan also consisted of Resident #64 was currently on IV therapy for antibiotics. The resident would be free of signs and symptoms of infection at IV insertion site, staff to administer IV medications and flushes per medical providers orders and report any abnormal findings. Review of Resident #64's physician orders dated June 2025 revealed the resident was in EBP related to Peripherally Inserted Central Catheter (PICC) when administering medication, dressing or bathing, showering, transferring in room or therapy gym, personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. Staff to administer Ceftriaxone Sodium 2 grams (gm) IV every 24 hours for soft tissue infection until 06/12/25 at 11:59 P.M. Observation on 06/11/25 at 9:54 A.M. of IV antibiotic administration for Resident #64 by Licensed Practical Nurse (LPN) #513 revealed LPN #513 did not wear proper Personal Protective Equipment (PPE) including a gown and gloves. Interview on 06/11/25 at 10:03 A.M. with LPN #513 revealed they verified Resident #64 was in EBP and stated they should have worn proper PPE including a gown and gloves to administer Resident #64's IV antibiotics. (continued on next page)

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	365732	A. Building B. Wing	06/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled Enhanced Barrier Precautions revealed Enhanced Barrier Precautions is an infection control intervention designed to reduce transmission of multi-drug-resistant organisms. Personal Protective Equipment required is a gown and gloves. EBP are indicated for residents with any of the following including indwelling medical devices for example central lines such as PICC lines. Review of the facility policy titled Intermittent Infusion, last revised 12/2014 revealed under General Guidance number three Administration sets used for intermittent therapy will be changed every 24 hours.