STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366113	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health Care Center Inc	1355 Churchill Hubbard Rd Youngstown, OH 44505

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview and facility policy review, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent, accurately and timely assess, promote healing and prevent pressure ulcer/wound infection from occurring. This affected one (Resident #95) of three residents reviewed for pressure ulcers. The facility census was 93. Actual Harm occurred on 07/03/25 when Resident #95 was assessed to have an acute change in condition requiring hospitalization. Upon hospital assessment, the resident was assessed to have a Stage II pressure ulcer to the sacrum with extensive gas forming soft tissue infection at the lower back extending to the tip of the coccyx measuring 9.0 centimeters (cm) by 2.3 cm by 16.1 cm. Prior to the development of the pressure ulcer infection, the facility failed to ensure effective ongoing monitoring and adequate interventions were in place to prevent the wound infection and subsequent hospitalization for treatment. Findings include:A review of Resident #95's closed clinical record revealed an admission date of 05/08/25 with diagnoses including left above the knee amputation, severe protein-calorie malnutrition, acute respiratory failure with hypoxia, pleural effusion, necrotizing fasciitis (Bacterial infection that rapidly destroys the skin, fat, and soft tissues surrounding muscles.), diabetes mellitus, hypothyroidism, high blood pressure, and gastroesophageal reflux disease. Resident #95 was discharged from the facility on 07/25/25. A review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #95 was cognitively intact. The assessment revealed the resident had no behaviors and she was assessed to be dependent on staff for toileting hygiene, transfers, and showers. The assessment revealed the resident required partial to moderate assistance with bed mobility, was always incontinent of urine and frequently incontinent of bowel. The resident was assessed to be at risk for pressure ulcer development, had no pressure ulcers, and had moisture associated skin damage (MASD). The assessment included the resident had pressure reducing devices to the bed and chair. A review of Resident #95's plan of care initiated on 05/19/25 revealed Resident #95 was at risk for the development of pressure ulcers related to limited mobility, left below the knee amputation with noted episodes of refusing boots to offload pressure to the heels and moisture associated buttocks/sacrum, thin fragile skin, and multiple bony prominences. The plan of care indicated on 05/20/25 Resident #95 frequently chose not to be repositioned, removed pillows when used to assist with side positioning, removed pressure reduction boots and informed the staff I move around plenty. The goal of the plan of care was for Resident #95 to have intact skin, free of redness, blisters or discoloration. Interventions on the plan of care included administering medications/treatments as ordered by the physician and monitor for side effects and effectiveness. Follow the facility policies/protocols for the prevention of skin breakdown, including the use of pressure reducing mattress to the bed, inform family/caregivers of any new area of skin breakdown, monitor nutritional status, serve diet as ordered, monitor food intake and record, monitor/document/report as needed any changes in skin appearance, color, wound healing, signs and symptoms of infection, wound size measurements and stage of wound, obtain and monitor laboratory/diagnostic work as ordered and report results to the physician, and treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. A review of Resident #95's physician's orders revealed an ordered dated 05/19/25 to cleanse coccyx with normal saline, pat dry, apply Allevyn Life dressing (dressing for the prevention and treatment of pressure injuries and other wounds) to the coccyx to pad and protect the area every other day and as needed for preventative treatment every night shift (11:00 P. M. to 7:00 A.M.). The order was noted due to the resident's history of a healed pressure ulcer to this area. The order indicated to sign and date the dressing when completed. A review of Resident #95's medical record revealed a skin evaluation assessment dated [DATE]. The assessment included the area was cleaned with normal saline, pat dried and a dry dressing was applied as ordered to pad and protect. The assessment note included the resident's skin was intact and the dressing remained dry and intact. A review of Resident #95's weekly skin evaluation/assessment dated [DATE], completed by Licensed Practical Nurse (LPN) #100, documented the resident had no new areas of skin breakdown identified, and dressing was intact to the coccyx. The evaluation included the resident's skin was intact with no new issues. The assessment indicated Resident #95 was at risk for the development of pressure ulcers. (However, there was no evidence the dressing that was in place at the time of the assessment on this date (used to pad and protect) was actually removed during this skin evaluation to determine if the resident had skin breakdown to

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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	Based on record review, observation, interview and facility policy review, the facility failed to ensure staff performed hand hygiene to prevent the cross contamination of germs during Resident #61 and Resident #44's medication administration and Resident #58's incontinence care. This affected two (Residents #61 and #44) out of seven residents observed for medication administration and one (Resident #58) out of three residents reviewed for incontinence care. The facility census was 93. Findings include:1. A review of Resident #61's medical record revealed an admission date of 01/22/25 with diagnoses including dementia, chronic kidney disease, anxiety, gastroesophageal reflux disease, depression, high blood pressure, cerebral vascular disease with stroke, influenza, encephalopathy, high cholesterol, and urinary tract infection. Resident #61's Medication Administration Record (MAR) dated 09/01/25 to 09/30/25 indicated to administer the following medications orally during the evening: Multivitamin one tablet (supplement) Cyproheptadine hydrochloride 4 milligrams (mg) (antihistamine) 2. A review of Resident #44's medical record revealed an admission date of 07/19/25 with diagnoses including atherosclerotic heart disease, aortocoronary bypass graft, cerebral vascular disease with stroke, heart disease with heart failure, heart arrhythmias, prosthetic heart valve, kidney disease, chronic obstructive pulmonary disease, diabetes mellitus, bone, digestive organ and prostate cancer, anemia, high blood pressure and cholesterol, gastroesophageal reflux disease, vitamin D deficiency, obesity, sleep apnea, reflex uropathy with urinary tract infection. A review of Resident #44's MAR dated 09/01/25 to 09/30/25 indicated to administer the following medications in the evening orally: Tamsulosin 0.4 mg (medication to treat benign prostatic hypertrophy) An observation on 09/08/25 between 3:30 P.M. and 4:00 P.M. of Licensed Practical Nurse (LPN) #100 administer medications to Resident #61 and Resident #44 revealed a failure to perform hand hygiene to prevent the spread of germs. LPN #100 administered medications to Resident #81 and did not perform hand hygiene and approached the medication cart. LPN #100 proceeded to obtain and dispense Resident #61's medications from the medication cart into a medication cup. LPN #100 then entered Resident #61's room and administered the cup of medications to Resident #61. LPN #100 exited Resident #44's room and did not perform hand hygiene and proceeded to obtain Resident #44's medications from the medication cart. LPN #100 was stopped and asked to perform hand hygiene before obtaining the medications from the medication cart. An interview with LPN #100 on 09/08/25 at 4:00 P.M. verified she had failed to perform hand hygiene between Resident #81's, Resident #61's and Resident #44's medication administration task. 3. A review of Resident #97's medical record revealed an admission date of 09/05/25 with diagnoses including heart attack, respiratory failure, obstructive sleep apnea, morbid obesity, venous insufficiency, constipation, heart failure, chronic right/left calf ulcers, dermatophytosis, soft tissue disorder, lymphedema, and plasma-protein disorder. Resident #97's immediate needs plan of care initiated on 09/05/25 indicated Resident #97 had bowel and bladder incontinence, needed two staff to assist her with toileting needs. An observation on 09/10/25 at 7:35 A.M. of Certified Nursing Assistant (CNA) #104 and CNA Supervisor (CNAS) #105 assist Resident #97 with incontinence care revealed a failure to perform hand hygiene to prevent the spread of germs. CNA #104 gathered the supplies needed for the task and placed the items on the over-the-bed table. CNA #104 donned a pair of gloves and proceeded to clean Resident #97's perineal area and buttocks of feces using several wet disposable wipes. CNA #104 did not remove her soiled gloves and perform hand hygiene upon completing the incontinence care task. CNA #104 then proceeded to assist the resident with donning heel protector boots, a pair of pants and placed the Hoyer (mechanical lift) pad under Resident #97 preparing to transfer Resident #97 to her wheelchair using the same soiled gloved hands she used for the incontinence care task. An interview with CNA #104 on 09/10/25 at 8:00 A.M. verified the above findings and agreed she should have removed her soiled gloves and performed hand hygiene after completing Resident #97's incontinence care. The facility policy and procedure titled Handwashing/Hand Hygiene dated 11/2024 indicated the policy was all personnel shall follow our established handwashing/hand hygiene procedures to prevent the spread of infection and disease to other residents, personnel and visitors. This policy is based on Centers for Disease Control and Prevention (CDC) guidance for healthcare providers. Employees must perform appropriate fifteen (15) second handwashing using antimicrobial or non-antimicrobial soap and water under the following conditions: a. When hands are visibly dirty or soiled with blood or other body fluids.b. After caring for a person with known or suspected infectious diarrhea.c. After known or suspected exposure to spores, e.g. B. anthracis, c. difficile outbreaks.d. Before eating and after using a restroom.If hands are not visibly soiled, use of an