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	03/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure Resident #45 was treated with dignity and respect by failing to provide appropriate clothing and coverings to maintain privacy and dignity. This affected one resident (#45) out of two residents investigated for dignity. In addition, the facility failed to ensure the call light was within reach for Resident #45. This affected one resident (#45) out of eight residents investigated for call lights. The facility census was 101.Findings include:1. Record reviewed for Resident #45 revealed an admission date of 06/29/25 with diagnoses including Parkinson's disease, muscle wasting and atrophy, muscle weakness, and adult failure to thrive. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #45 was cognitively intact. The resident required substantial/maximal assistance for upper and lower body dressing. Observation on 03/02/26 at 2:56 P.M. revealed Resident #45 lying in bed with the door to the room open, the curtain open with no blanket or sheet for the resident to cover himself. Resident #45 was wearing a t-shirt and incontinence brief. Interview with Resident #45 on 03/02/26 at the time of the observation confirmed he was not comfortable lying in his bed uncovered and exposed and would like to be covered up. Interview on 03/02/26 at 3:02 P.M. with Personal Care Aide (PCA) # 541 verified Resident #45 could be seen from the hallway, was not covered, had no blanket or sheet available, and the resident was wearing only an incontinence brief and t-shirt. PCA #541 verified Resident #45 should have been covered. 2. Record reviewed for Resident #45 revealed an admission date of 06/29/25 with diagnoses including Parkinson's disease, muscle wasting and atrophy, muscle weakness, and adult failure to thrive. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #45 was cognitively intact and required substantial/maximal assistance for upper and lower body dressing. Review of the care plan revealed staff was to ensure call light is in reach (07/07/25).Observation on 03/02/26 at 2:56 P.M. revealed Resident #45 lying in bed with call light not in reach. The resident confirmed due to limitations of hands and arms he was unable to reach call light placed over his right shoulder.Interview on 03/02/26 at 3:02 P.M. with Personal Care Aide #541 (PCA) confirmed Resident #45 was not able to reach his call light.Observation on 03/03/26 at 11:54 A.M. revealed Resident #45's call light was not in reach. The call light was placed on the bed near the resident's right shoulder. He stated PCA #575 had just finished personal care, and he was not able to reach his call light.Interview on 03/03/26 at 11:56 A.M. with PCA #575 confirmed she completed Resident #45's personal care and did not ensure his call light was within reach before leaving the room. Interview on 03/03/26 at 12:15 P.M. with Physical Therapist #407 revealed due to Resident #45's primary diagnosis of Parkinson's disease, the resident's ability to move his arms and hands depended of the day; some days Resident #45 was able to use his arms and hands more than normal but was limited on an ongoing basis.Phone interview on 03/04/26 at 1:04 P.M. with Resident #45's uncle revealed on numerous occasions he observed the call light was not within reach for the resident upon arrival for visits.This deficiency represents non-compliance investigated under Master Complaint Number 2724622 and Complaint Number 2715174.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, and review of the facility policy, the facility failed to provide showers as scheduled and per resident preferences for residents who required assistance with bathing. This affected five residents (#55, #81, #87, #90, and #98) out of five reviewed for bathing. The facility census was 101. Findings include:1. Review of the medical record for Resident #81 revealed an admission date of 03/22/16 with diagnoses including major depressive disorder, hypertension, Barrett's esophagus, atrial flutter, muscle weakness, congestive heart failure, chronic kidney disease, hypothyroidism, and peripheral vascular disease. Review of the care plan dated 10/03/19 revealed Resident #81 would receive a person-centered care plan based on physician orders and resident choices. Interventions included assistance of one staff for bathing and sit to stand lift for transfers. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 had no cognitive impairment. The assessment indicated Resident #81 was dependent on staff for showering/bathing and dependent on staff for transfers. Review of the shower schedules revealed Resident #81 was scheduled for showers on Wednesdays and Saturdays. Review of the shower documentation from 09/01/25 through 03/01/26 revealed Resident #81 received 21 showers and two bed baths out of 50 scheduled shower days with six refusals documented on 09/01/25, 11/08/25, 11/12/25, 11/26/25, 12/03/25, and 01/10/26. Review of the progress note dated 02/19/26 at 12:27 P.M. revealed Resident #81's daughter requested a care plan meeting with the Administrator and Director of Nursing (DON). Review of the progress note dated 02/27/26 at 11:23 A.M. revealed the Administrator met with Resident #81's daughter for a care plan meeting, which included discussions about the shower schedules. On 03/04/26 at 10:01 A.M., an interview with Certified Nursing Assistant (CNA) #599 stated all showers were documented electronically on tablets and if it was blank, then no shower was provided. On 03/04/26 at 3:04 P.M., an interview with Licensed Practical Nurse (LPN) #515 confirmed showers were only documented electronically, and documentation was an issue. LPN #515 verified the shower documentation and that multiple days were documented as not applicable, including scheduled shower days for Resident #81. LPN #515 stated if it was not documented then it was not done. On 03/04/26 at 4:55 P.M., an interview with Corporate Quality Assurance (QA) Registered Nurse (RN) #499 confirmed shower documentation had been an ongoing concern at the facility. Review of the facility's policy titled Bath (Shower), dated 02/2026, revealed the frequency of baths and showers were based on resident preference as noted on the care plan. 2. Review of the medical record for Resident #87 revealed an admission date of 01/06/24 with diagnoses including vertigo, anxiety disorder, muscle wasting and atrophy, major depressive disorder, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hemiplegia and hemiparesis following cerebral infarction, muscle weakness, and limitations of activities due to disability. Review of the annual MDS assessment, dated 01/09/26, revealed Resident #87 had no cognitive impairment. The assessment did not indicate what kind of assistance was required for showering/bathing, and the question was answered not applicable. Review of the care plan dated 01/06/24 revealed Resident #87 would receive a person-centered care plan based on physician orders and resident choices. Interventions included assistance from two staff for bathing and a mechanical lift for transfers. Review of the shower schedules revealed Resident #87 was scheduled for showers on Wednesdays and Saturdays. Review of the shower documentation from 09/01/25 through 03/01/26 revealed Resident #87 received eight showers and 11 bed baths out of 52 scheduled shower days with only one refusal documented on 11/08/25. On 03/02/26 at 3:35 P.M., an interview with Resident #87 stated she did not receive showers as often as she would like. On 03/04/26 at 10:01 A.M., an interview with CNA #599 stated all showers were documented electronically on tablets and if it was blank, then no shower was provided. On 03/04/26 at 3:04 P.M., an interview with LPN #515 confirmed showers were only documented electronically, and documentation was an issue. LPN #515 verified the shower documentation. LPN #515 stated if it was not documented then it was not done. On 03/04/26 at 4:55 P.M., an interview with Corporate QA RN #499 confirmed shower documentation had been an ongoing concern at the facility. Review of the facility's policy titled Bath (Shower), dated 02/2026, revealed the frequency of baths and showers were based on resident preference as noted on the care plan. 3. Review of the medical record for Resident #90 revealed an admission date of 01/14/26 with diagnoses including Alzheimer's disease, dementia with psychotic disturbance, adjustment disorder with anxiety, muscle weakness, and repeated falls. Review of the care plan dated 01/14/26 revealed Resident #90 would receive a person-centered care plan based on physician orders and resident choices. Interventions included assistance from one staff for bathing and transfers. Review of the admission MDS assessment dated [DATE] revealed Resident #90 had no cognitive impairment. The assessment indicated Resident #90 required substantial or maximal assistance for showering/bathing. Review of the physician's orders for Resident #90 identified orders for transfer assistance of one staff effective 01/28/26. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower schedules revealed Resident #90 was scheduled to receive showers on Tuesdays and Fridays. Review of shower documentation since admission for Resident #90 revealed nine showers were provided out of 13 scheduled shower days with no documented refusals. On 03/02/26 at 10:44 A.M., an interview with Resident #90 stated she did not get showers as scheduled. On 03/04/26 at 10:01 A.M., an interview with CNA #599 stated all showers were documented electronically on tablets and if it was blank, then no shower was provided. On 03/04/26 at 3:04 P.M., an interview with LPN #515 confirmed showers were only documented electronically, and documentation was an issue. LPN #515 verified the shower documentation. LPN #515 stated if it was not documented then it was not done. On 03/04/26 at 4:55 P.M., an interview with Corporate QA RN #499 confirmed shower documentation had been an ongoing concern at the facility. Review of the facility's policy titled Bath (Shower), dated 02/2026, revealed the frequency of baths and showers were based on resident preference as noted on the care plan. 4. Record review for Resident #98 revealed an admission date of 11/28/25 with diagnoses including periprosthetic fracture around an internal prosthetic left knee. Review of the care plan dated 11/28/25 indicated Resident #98 required two staff assistance with showers, and he was to receive showers twice weekly. Review of the MDS assessment dated [DATE] revealed Resident #98 was moderately cognitively impaired. Review of the facility's shower documentation indicated Resident #98's preferred shower Mondays and Thursdays. Interview on 03/02/26 at 10:47 A.M. revealed Resident #98 stated he was not receiving showers, and he had only received one in the past month. Review of the facility's shower documentation from 11/28/25 through 03/01/26 revealed there were 26 scheduled shower days within a 93-day period. Documentation showed the resident received only nine showers/bed baths, with one documented refusal. Interview with LPN #515 on 03/02/26 at 8:05 A.M. revealed residents should receive their showers according to their care plan and preferred schedule unless refused which should be documented. LPN #515 stated staff received an in-service on 02/13/26 regarding shower documentation. LPN #515 confirmed Resident #98 was scheduled to receive showers on Mondays and Thursdays and acknowledged the documentation did not show Resident #98 received showers as scheduled or documentation of refusals. Record review revealed staff received an in-service on shower documentation on 02/13/26. Review (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the shower documentation after the in-service training revealed Resident #98 had four scheduled shower opportunities with only one shower provided, and no documentation of refusal for the remaining missed showers. Review of the facility's policy titled Bath (Shower), dated 02/2026, revealed the frequency of baths and showers were based on resident preference as noted on the care plan. 5. Resident #55 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, gastroesophageal disease (GERD), generalized anxiety, aphasia, dysphagia, stroke, bone disorders, bradycardia, and obesity. Her cognition was severely impaired. Review of Resident #55's medical record revealed she was ordered showers on Mondays, Wednesdays, and Fridays. Family wanted notified if the resident refused. Progress notes on 02/15/26 and 02/21/26 revealed Resident #55 often refuses personal care, to include showers, incontinent care, and getting out of bed in the morning. Review of CNA documentation for showers revealed from 09/01/25 through 03/01/26, Resident #55 was scheduled for 79 showers. She received 46 showers and refused three showers, or 58.2 percent (%). In-service related to resident showers on 02/13/26 was completed by all nursing staff. After that, Resident #55 has had six scheduled showers and received four. Interview on 03/02/26 at 11:53 A.M. with Resident #55's daughter revealed the resident had not been receiving all her showers for several months. On 03/03/26 at 8:05 A.M., the Nurse Aide Supervisor, LPN #515 verified documentation did not indicate Resident #55 received her showers in accordance with her physician order. Review of the facility's policy titled Bath (Shower), dated 02/2026, revealed the frequency of baths and showers were based on resident preference as noted on the care plan. This deficiency represents non-compliance investigated under Master Complaint Number 2724622 and Complaint Number 2715174.