

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Liberty Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on observation, interview and facility policy review, the facility failed to ensure staff spoke to Resident #15 in a dignified manner. This affected one resident (#15) of three residents reviewed for dignity had the potential to affect all residents in the facility. The facility census was 101.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses including chronic respiratory failure, congestive heart failure, diabetes mellitus type two, depression, anxiety, hypertension, and morbid obesity. Resident #15 was also on Enhanced Barrier Precautions (EBP).</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was cognitively intact and had occasional bladder incontinence and frequent bowel incontinence.</p> <p>On 04/30/24 at 9:15 A.M. an observation revealed State tested Nurse Aide (STNA) #561 standing at the doorway of Resident #15 and hollering into the room asking the resident what was needed. Resident #15 was requesting different incontinence briefs and asked STNA #561 to come into the room. STNA #561 then hollered into the room that she was not coming in because she did not want to put on an isolation gown just to walk back out again and again asked Resident #15 what she wanted from the doorway. Licensed Practical Nurse (LPN) #578 was standing in the hallway and verified that STNA was hollering into the room of Resident #15 regarding her briefs at the time of the observation.</p> <p>On 04/30/24 at 9:15 A.M. observation of Resident #15's door revealed an EBP sign that stated gowns needed to be worn only when providing direct personal care.</p> <p>A review of the policy titled, Enhanced Barrier Precautions, dated March 2024, revealed personal protective equipment (gowns, gloves, and masks) was only necessary when performing high contact care activities. Personal protective equipment was not needed if entering the resident's room to talk.</p> <p>A review of the policy titled, Dignity, Respect and Privacy, dated June 2016, revealed all residents in the facility will be treated with kindness, dignity, and respect whenever talked with, cared for, or talked about.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00152199.</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>45441</p> <p>Based on record review, interview, facility self-reported incident (SRI) review and facility policy review, the facility failed to implement their abuse policy regarding thoroughly investigating an injury of unknown origin for Resident #8 and an allegation of staff-to-resident abuse for Resident #77. This affected two residents (#8 and #77) of three residents reviewed for abuse and had the potential to affect all 101 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including dementia, acute kidney failure, anxiety disorder, and adult failure to thrive.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was severely cognitively impaired. She required limited assistance of one person for transfers, dressing, eating, toilet use, and hygiene.</p> <p>Review of the facility SRI tracking number 241607 dated 11/29/23 revealed on the afternoon of 11/29/24 a bruise was noted under Resident #8's right eye and brought to the attention of the nurse. An SRI was submitted at that time. The investigation revealed the resident had severe cognitive impairment and had been getting suppositories and often tried to self-transfer to use the restroom. On 11/28/23 at 2:30 P.M. the resident was found in her bathroom with her head against the wall after trying to clean herself up from an uncontrolled bowel movement on her way there. She did not complain of any pain or discomfort and there were no witnesses to the incident. In the following days the bruise spread to under the resident's left eye and a tooth in her lower jaw fell out. The investigation concluded the resident bumped her face in the bathroom on the wall or handrail while toileting herself. The investigation did not include signed and dated witness statements of staff working at the time the injury, interviews or skin assessments of other residents, an assessment of Resident #8 or any education regarding injuries of unknown origin.</p> <p>Review of the nursing progress notes dated 12/01/23 revealed Resident #8 was missing most of a tooth on the bottom of her mouth. The resident had no information about the cause of the broken tooth. She had no pain and no problem eating. The physician and family were notified.</p> <p>Interview on 05/02/24 at 9:28 A.M. with the Administrator revealed the bruise was discovered in the common area. He confirmed the investigation revealed Resident #8 was found in her bathroom but had no written witness statements to attest to either of the above. He also confirmed he had no witness statements signed or dated by staff interviewed regarding the incident. He had no documented evidence other residents were interviewed or assessed for potential abuse.</p> <p>Interview on 5/02/24 at 9:31 A.M. with Registered Nurse (RN) #648 confirmed there were no witness statements from staff working at the time the injury was found and no assessment of Resident #8.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including amyotrophic lateral sclerosis (ALS), major depressive disorder, anxiety, and muscle weakness.</p> <p>Review of the facility SRI tracking number 244231 dated 02/15/24 revealed an allegation of staff-to-resident abuse was made by Resident #77. She stated on 02/08/24 at 7:15 P.M. State tested Nurse Aide (STNA) #608 purposely pulled her hair while removing her glasses strap stating it hurt because it was the hair behind her ear. The Administrator tried to call STNA #608 multiple times, and she had not answered her phone. The Administrator came to the facility on [DATE] and 02/18/24 to meet with STNA #608 before she started her scheduled shift. On 02/17/24, STNA #608 did not show up for work, and on 02/18/24, STNA #608 she came to the facility and told a nurse she was sick and left before the Administrator arrived. Her next scheduled day was 02/20/24, and again she did not show up for work. After interviewing other staff and residents, there were no other complaints regarding STNA #608's care practices. Through the investigation with Resident #77, who had been in contact with the ombudsman's office, she mentioned the incident to the ombudsman, but said she apologized to STNA #608, and they had worked it out. The resident has a diagnosis of ALS, and the Administrator was talking to her about an upcoming meeting when the incident was brought to his attention. Due to Resident #77's condition, she wears a glasses strap to keep her glasses from falling down. The strap has rubber rings on both ends that go around the bow of the glasses. Her hair had allegedly been pulled by the rubber when STNA #608 tried to remove the glasses. Due to STNA #608's avoidance of the Administrator, the facility terminated her employment. The facility's investigative documentation consisted of the SRI report form, one typed page with a statement from Resident #77, and one handwritten page with partial documentation of staff interviews. No other documentation was provided regarding the investigation of the alleged staff-to-resident physical abuse.</p> <p>On 05/02/24 at 12:28 P.M., interview with the Administrator verified the lack of documentation included in the facility's investigation of the SRI involving Resident #77.</p> <p>On 05/02/24 at 1:06 P.M., interview with Nurse Aide Supervisor #534 verified the documentation of the facility's investigation of the SRI involving Resident #77. She confirmed that no skin assessments were completed for Resident #77 regarding this incident.</p> <p>Review of the facility's policy titled Resident Abuse Prevention Practices, dated 09/2019, revealed alleged, suspected, or observed abuse, neglect, and/or mistreatment of a resident would be thoroughly investigated by the Administrator and Director of Nursing or designee. The investigation would begin immediately, the resident would be examined for injury at the time of complaint, appropriate medical attention would be given as necessary, and written statements would be taken and interviews conducted with anyone involved or witnessing the event (including alleged victim, alleged perpetrator, and witnesses who may have knowledge of the allegation).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>45441</p> <p>Based on record review, interview, facility self-reported incident (SRI) review and facility policy review, the facility failed to thoroughly investigate an injury of unknown origin for Resident #8 and an allegation of staff-to-resident abuse for Resident #77. This affected two residents (#8 and #77) of three residents reviewed for abuse and had the potential to affect all 101 residents residing in the facility.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including dementia, acute kidney failure, anxiety disorder, and adult failure to thrive.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was severely cognitively impaired. She required limited assistance of one person for transfers, dressing, eating, toilet use, and hygiene.</p> <p>Review of the facility SRI tracking number 241607 dated 11/29/23 revealed on the afternoon of 11/29/24 a bruise was noted under Resident #8's right eye and brought to the attention of the nurse. An SRI was submitted at that time. The investigation revealed the resident had severe cognitive impairment and had been getting suppositories and often tried to self-transfer to use the restroom. On 11/28/23 at 2:30 P.M. the resident was found in her bathroom with her head against the wall after trying to clean herself up from an uncontrolled bowel movement on her way there. She did not complain of any pain or discomfort and there were no witnesses to the incident. In the following days the bruise spread to under the resident's left eye and a tooth in her lower jaw fell out. The investigation concluded the resident bumped her face in the bathroom on the wall or handrail while toileting herself. The investigation did not include signed and dated witness statements of staff working at the time the injury, interviews or skin assessments of other residents, an assessment of Resident #8 or any education regarding injuries of unknown origin.</p> <p>Review of the nursing progress notes dated 12/01/23 revealed Resident #8 was missing most of a tooth on the bottom of her mouth. The resident had no information about the cause of the broken tooth. She had no pain and no problem eating. The physician and family were notified.</p> <p>Interview on 05/02/24 at 9:28 A.M. with the Administrator revealed the bruise was discovered in the common area. He confirmed the investigation revealed Resident #8 was found in her bathroom but had no written witness statements to attest to either of the above. He also confirmed he had no witness statements signed or dated by staff interviewed regarding the incident. He had no documented evidence other residents were interviewed or assessed for potential abuse.</p> <p>Interview on 5/02/24 at 9:31 A.M. with Registered Nurse (RN) #648 confirmed there were no witness statements from staff working at the time the injury was found and no assessment of Resident #8.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including amyotrophic lateral sclerosis (ALS), major depressive disorder, anxiety, and muscle weakness.</p> <p>Review of the facility SRI tracking number 244231 dated 02/15/24 revealed an allegation of staff-to-resident abuse was made by Resident #77. She stated on 02/08/24 at 7:15 P.M. State tested Nurse Aide (STNA) #608 purposely pulled her hair while removing her glasses strap stating it hurt because it was the hair behind her ear. The Administrator tried to call STNA #608 multiple times, and she had not answered her phone. The Administrator came to the facility on [DATE] and 02/18/24 to meet with STNA #608 before she started her scheduled shift. On 02/17/24, STNA #608 did not show up for work, and on 02/18/24, STNA #608 she came to the facility and told a nurse she was sick and left before the Administrator arrived. Her next scheduled day was 02/20/24, and again she did not show up for work. After interviewing other staff and residents, there were no other complaints regarding STNA #608's care practices. Through the investigation with Resident #77, who had been in contact with the ombudsman's office, she mentioned the incident to the ombudsman, but said she apologized to STNA #608, and they had worked it out. The resident has a diagnosis of ALS, and the Administrator was talking to her about an upcoming meeting when the incident was brought to his attention. Due to Resident #77's condition, she wears a glasses strap to keep her glasses from falling down. The strap has rubber rings on both ends that go around the bow of the glasses. Her hair had allegedly been pulled by the rubber when STNA #608 tried to remove the glasses. Due to STNA #608's avoidance of the Administrator, the facility terminated her employment. The facility's investigative documentation consisted of the SRI report form, one typed page with a statement from Resident #77, and one handwritten page with partial documentation of staff interviews. No other documentation was provided regarding the investigation of the alleged staff-to-resident physical abuse.</p> <p>On 05/02/24 at 12:28 P.M., interview with the Administrator verified the lack of documentation included in the facility's investigation of the SRI involving Resident #77.</p> <p>On 05/02/24 at 1:06 P.M., interview with Nurse Aide Supervisor #534 verified the documentation of the facility's investigation of the SRI involving Resident #77. She confirmed that no skin assessments were completed for Resident #77 regarding this incident.</p> <p>Review of the facility's policy titled Resident Abuse Prevention Practices, dated 09/2019, revealed alleged, suspected, or observed abuse, neglect, and/or mistreatment of a resident would be thoroughly investigated by the Administrator and Director of Nursing or designee. The investigation would begin immediately, the resident would be examined for injury at the time of complaint, appropriate medical attention would be given as necessary, and written statements would be taken and interviews conducted with anyone involved or witnessing the event (including alleged victim, alleged perpetrator, and witnesses who may have knowledge of the allegation).</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for the care and maintenance of an enteral feeding tube for Resident #92. This affected one resident (#92) of two residents reviewed for enteral feedings. The facility census was 101.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #92 revealed an admitted [DATE] with diagnoses including muscle wasting and atrophy, dysphagia, dementia, and chronic kidney disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 received 51% or more calories per day and 501 ml or more fluid per day from tube feeding.</p> <p>Review of the order history for Resident #92 revealed she had consistently had physician's orders for enteral feedings or flushes since 12/18/23. Current physician's orders included nothing by mouth (NPO) effective 04/09/24, check enteral tube placement every eight hours effective 04/25/24, cleanse enteral feeding site with soap and water every night shift effective 04/25/24, change syringe every night shift effective 04/25/24, observe for signs of dehydration, nausea, vomiting, distention, diarrhea, reflux, constipation, and breath sounds every shift effective 04/25/24, change enteral feeding tube as needed effective 04/25/24, auto water flush enteral tube at 50 milliliters (ml) per hour effective 04/29/24, and continuous enteral feeding of Fibersource HN at 55 ml per hour effective 04/29/24.</p> <p>Review of the comprehensive care plan revised 04/25/24 revealed there was no care plan in place for Resident #92's enteral feeding tube.</p> <p>On 05/01/24 at 4:41 P.M., interview with Corporate Quality Assurance (QA) Nurse #648 verified there was no care plan developed for the enteral feeding tube for Resident #92.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on observation, interview, record review and facility policy review the facility failed to provide oral care for Resident #23 and fingernail care for Resident #50. This affected two residents (#23 and #50) of 83 residents observed for assistance with personal care. The facility census was 101.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #23 was admitted on [DATE] with diagnoses including chronic kidney disease, acute kidney failure, diabetes mellitus type two, cerebral infarct, and muscle wasting.</p> <p>Review of the Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact.</p> <p>A care plan dated 03/01/24 revealed Resident #23 needed the assistance of two people for bathing, grooming, and hygiene.</p> <p>A review of Resident #23 shower sheets revealed the most recent shower was 04/24/24.</p> <p>On 04/29/24 at 9:42 A.M. an observation and interview of Resident #23 revealed a white buildup between his lower teeth. Resident #23 stated staff had not assisted him to brush his teeth that day.</p> <p>On 04/30/24 at 1:00 P.M. an interview and observation of Resident #23 revealed a white buildup between his lower teeth. Resident #23 stated he had not had his teeth brushed again.</p> <p>On 04/30/24 at 2:15 PM interview with Corporate Quality Assurance Registered Nurse (QARN) #648 revealed tooth brushing was to be done in the morning and evening. QARN #648 verified there was no documented evidence in Resident #23's medical record to support oral care that had been completed or refused by Resident #23.</p> <p>Review of the facility policy titled, A.M. Care (Morning Care) and P.M. Care (Bedtime Care), both dated January 2022, revealed staff were to assist with oral hygiene.</p> <p>2. Review of the medical record revealed Resident #50 was admitted [DATE] with diagnoses including unspecified dementia, depression, weakness, hypertension, and diabetes mellitus type two.</p> <p>Review of the Admission MDS assessment dated [DATE] revealed Resident #50 had moderate cognitive impairment.</p> <p>Review of the care plan dated 02/12/24 revealed Resident #50 needed the assistance of one person for bathing and hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/29/24 at 8:45 A.M. an observation of Resident #50 revealed the resident lying in bed. Resident #50 had long fingernails that were curling at the ends. There was a black substance underneath her fingernails.</p> <p>On 04/30/24 at 8:15 A.M. an observation of Resident #50 revealed fingernails ungroomed with a black substance underneath.</p> <p>On 04/30/24 at 1:45 PM. an observation during incontinence care revealed Resident #50 continued to have fingernails that were long and dirty. State tested Nurse Aide (STNA) #635 verified the unkept fingernails at the time of the observation. STNA #635 stated nail care was to be done with bathing and as needed.</p> <p>Review of the facility policy titled, Nails, Care of Fingernails, dated November 2021, revealed fingernail care will be done for the non-diabetic residents by the STNA during or after the resident's shower/bath and as needed. The STNA will examine the nails of the diabetic resident during their shower and inform the nurse of any issues with the resident's fingernails. The purpose of the policy is to promote cleanliness, prevent infection, injury, and odors and to improve appearance, promote self-esteem and contribute to a sense of wellbeing.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00152199.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on observation, interview, record review and facility policy review the facility failed to provide proper positioning in a wheelchair as ordered for Resident #10. This affected one resident (#10) of 34 residents reviewed for positioning. The facility census was 101.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #10 was admitted on [DATE] with diagnoses including hemiplegia following a cerebral infarction (a weakening of one side of the body following a stroke), epileptic seizures, depression, and chronic obstructive pulmonary disease. Significant orders included Hoyer lift (a mechanical lift used to transfer due to inability to transfer independently) for transfers, check residents left arm placement while in wheelchair to prevent being pinched inside of chair, and left arm to be elevated on pillow while in the wheelchair.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had severe cognitive impairment.</p> <p>Review of the plan of care dated 04/05/24 revealed Resident #10 was to have his left arm elevated on a pillow while in the wheelchair.</p> <p>On 04/29/24 at 12:40 P.M. an observation of Resident #10 revealed him sitting in the East common area in his wheelchair. Resident #10's left arm was wedged between his body and the wheelchair.</p> <p>On 04/30/24 at 7:30 A.M. an observation of Resident #10 revealed him in the main dining room for breakfast. Resident #10's left arm was resting on his lap. There was not a pillow present for positioning of the left arm as ordered. Interview with Licensed Practical Nurse (LPN) #572 verified there was no pillow for positioning as ordered at the time of the observation.</p> <p>Review of the facility policy titled, Wheelchair, Use Of, dated 02/2024, revealed, in point #8, to make sure all positioning devices were in place as ordered.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to ensure hearing aides were ordered and available as needed for Residents #3 and #13). This affected two residents (#3 and #13) of three residents reviewed for communication concerns. The facility census was 101.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, chronic pain, depression, end stage renal disease, hypertension, and unspecified hearing loss.</p> <p>Review of the audiology visit dated 09/18/23 for Resident #3 revealed the resident was referred by the facility for decreased hearing. She was recommended for hearing aids with follow up in one to three months.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact. She was independent with eating, required supervision for toileting, set up help for oral hygiene and personal hygiene and partial to moderate assistance for showering. She had minimal difficulty hearing and did not have hearing aids.</p> <p>Review of the care plan dated 01/28/24 revealed Resident #3 had a communication problem due to a hearing deficit. Interventions included anticipating the resident's needs, allowing adequate time to respond, repeating as necessary, using alternative communication tools as needed and referrals to audiology for hearing consults as needed.</p> <p>Review of the audiology visit dated 04/19/24 revealed Resident #3 was upset that she had never been fitted for hearing aids.</p> <p>Interview on 04/29/24 at 10:06 A.M. with Resident #3 revealed she was supposed to have hearing aids one year ago. She revealed she asked the Administrator about them a few months ago, and she was told they had not been ordered yet. The resident was tearful when discussing the matter.</p> <p>Interview on 05/01/24 at 12:53 P.M. with Registered Nurse (RN) #648 confirmed Resident #3's audiology report from 09/18/23 recommended the resident be fitting for hearing aids. RN #648 also confirmed this recommendation was never followed up on by the facility.</p> <p>2. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), muscle weakness, and anemia.</p> <p>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #13 was severely cognitively impaired. She required set up help for eating, oral hygiene, and personal hygiene and partial to moderate assistance for toileting and showering. She had minimal difficulty hearing and used a hearing aide.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician's orders for April 2024 revealed an order for the Resident #13 to have hearing aids in during the day. They were to be removed at night and placed on the charger. The order began 04/28/23.</p> <p>Review of the care plan dated 03/13/24 revealed Resident #13 would receive person centered care based on the physician's orders and the resident's choices. Interventions included bilateral hearing aids.</p> <p>Observation and interview on 04/29/24 at 8:56 A.M. with Resident #13 revealed she was very hard of hearing. She reported she used to have two hearing aids but now only had one and did not know where it was.</p> <p>Interview on 05/01/24 at 12:53 P.M. with RN #648 confirmed Resident #13 lost one of her hearing aids in August 2023, and the facility had not yet followed up with the resident or her family to see how they wanted to proceed with replacing the device.</p> <p>Review of the undated facility policy titled Vision and Hearing: Making Appointments, Transportation revealed the facility would ensure all residents received the proper treatment and assistive devices to maintain hearing abilities.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on medical record review, review of the dialysis agreements, staff interviews and review of the facility policy, the facility failed to complete dialysis assessments according to the physician's orders and failed to ensure residents had reliable transportation to and from the dialysis center. This affected two residents (#35 and #406) of two residents reviewed for dialysis treatments. The facility census was 101.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #35 revealed an admitted [DATE] and readmitted [DATE]. Diagnoses included end stage renal disease, dependence on renal dialysis, type two diabetes mellitus, and anemia in chronic kidney disease.</p> <p>Review of the physician's orders for April 2024 identified orders for dialysis on Monday, Wednesday, and Friday at 11:30 A.M. (ordered 01/04/24), pre-dialysis assessment on dialysis days every day shift on Monday, Wednesday, Friday (ordered 05/17/23), and post-dialysis assessment on dialysis days every evening shift on Monday, Wednesday, Friday (ordered 05/15/23).</p> <p>Review of the progress notes for October 2023 through April 2024 revealed concerns regarding the contracted transportation company arriving on time or at all to transport Resident #35 to and from his dialysis appointments on 10/11/23, 10/27/23, 10/28/23, 11/15/23, 11/21/23, 11/29/23, 01/10/24, 01/11/24, and 01/12/24.</p> <p>Review of the facility's dialysis assessments for March 2024 through April 2024 for Resident #35 revealed the following:</p> <p>No pre-dialysis assessment was completed on 03/06/24, 03/13/24, 03/25/24, 04/03/24, 04/07/24, 04/10/24, 04/12/24, and 04/15/24.</p> <p>No post-dialysis assessment was completed on 03/01/24, 04/24/24, 04/26/24, and 04/29/24.</p> <p>No pre-dialysis or post-dialysis assessments were completed on 03/22/24, 03/27/24, 03/29/24, and 04/19/24.</p> <p>On 04/30/24 at 1:55 P.M., interview with Clinical Quality Assurance (QA) Nurse #647 verified there were issues with transportation. She also confirmed dialysis assessments were not completed as ordered.</p> <p>Review of the facility's agreement with Resident #35's dialysis center revealed the facility would assume full responsibility for obtaining services that meet professional standards and principles that apply to professionals providing such services and the timeliness of the services.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Transportation Policy, dated 01/2023, revealed the facility would work with the resident representative and contracted transport companies to schedule transportation for outside appointments (physician office, dialysis, dental appointments, etc.). The policy also indicated the facility had access to a company wheelchair accessible van that could be called for transportation that was unable to be accommodated by the local transportation provider and the company's transport would need to be scheduled in advance as availability was limited.</p> <p>2. Review of the medical record for Resident #406 revealed an admitted [DATE] and re-admitted [DATE]. Diagnoses included end stage renal disease, dependence on renal dialysis, and congestive heart failure.</p> <p>Review of the physician's orders for April 2024 identified orders for dialysis on Tuesday, Thursday, and Saturday at 11:45 A.M. (ordered 04/02/24), pre-dialysis assessment to be completed every day shift on Tuesday, Thursday, and Saturday (ordered 03/26/24), and post-dialysis assessment to be completed every evening shift Tuesday, Thursday, and Saturday (ordered 03/26/24).</p> <p>Review of the progress note dated 03/30/24 at 2:23 P.M. revealed Resident #406 was sent to the emergency room for dialysis treatments because the contracted transportation company did not arrive to transport Resident #406 to the dialysis center for his scheduled dialysis appointment.</p> <p>Review of the progress note dated 04/02/24 at 11:48 A.M. revealed the contracted transportation company arrived at the facility with a vehicle that was not equipped to transport Resident #406. Resident #406's dialysis appointment had to be rescheduled.</p> <p>Review of the dialysis missed or shortened treatments report for 03/26/24 through 04/29/24 revealed Resident #406 did not receive dialysis at the dialysis center on 03/30/24 and arrived late with the inability to extend treatment on 04/03/24, 04/06/24, 04/09/24, and 04/18/24. The report indicated Resident #406 had missed five hours and 21 minutes of the ordered dialysis run time due to missed appointments and late start times.</p> <p>Review of the care plan, initiated 04/04/24, revealed Resident #406 required dialysis related to renal failure. Interventions included encouraging Resident #406 to attend dialysis appointments, monitor for signs or symptoms of infection to the dialysis port site, changes in level of consciousness, changes in skin turgor, changes in oral mucosa, and changes in heart and lung sounds.</p> <p>Review of the facility's dialysis assessments for March 2024 through April 2024 for Resident #406 revealed the following:</p> <p>No pre-dialysis assessment was completed on 04/06/24, 04/11/24, and 04/20/24.</p> <p>No post-dialysis assessment was completed on 04/23/24 and 04/27/24.</p> <p>No pre-dialysis or post-dialysis assessments were completed on 04/04/24, 04/09/24, 04/13/24, 04/25/24, and 04/29/24.</p> <p>On 04/30/24 at 1:55 P.M., interview with Clinical QA Nurse #647 verified there were issues with transportation. She also confirmed dialysis assessments were not completed as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 3:40 P.M., interview with Corporate QA Nurse #648 stated the facility had no control over the contracted transportation company not showing up as scheduled and that timely arrangements were made for Resident #406 to get his dialysis treatment at the emergency room . She stated the facility's company did have transportation vehicles, but they did not have enough to transport residents at all of their facilities.</p> <p>Review of the facility's agreement with Resident #406's dialysis center revealed the facility would be responsible for the development and implementation of the plan of care.</p> <p>Review of the facility's policy titled Transportation Policy, dated 01/2023, revealed the facility would work with the resident representative and contracted transport companies to schedule transportation for outside appointments (physician office, dialysis, dental appointments, etc.). The policy also indicated the facility had access to a company wheelchair accessible van that could be called for transportation that was unable to be accommodated by the local transportation provider and the company's transport would need to be scheduled in advance as availability was limited.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>39973</p> <p>Based on interview, schedule review, Payroll Based Journal (PBJ) review and Facility Annual Assessment review, that facility failed to ensure there was adequate Registered Nurse (RN) coverage for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 101 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the PBJ Staffing Data Report CASPER Report 1705D 10/01/23 though 12/31/23 revealed the facility had four or more days within the quarter with no RN coverage and had a one-star staffing rating.</p> <p>Review of the Nursing Assignment forms for 10/15/23, 10/29/23, 11/05/23, 11/11/23, 11/12/23, 11/22/23, 11/23/24, 11/25/23, 11/26/23, 12/02/24, 12/03/23, 12/10/23, and 01/20/24, revealed there were no RN's present working in the facility.</p> <p>Review of the Facility Annual Assessment, dated 03/01/24, revealed under licensed nurses the facility would have one full time Director of Nursing, two full time Clinical Directors and under the area of RN they would have two full time Minimum Data Set (MDS) RNs plus 200-336 hours of a RN per two weeks. The facility assessment did not reference that they would have at least eight consecutive hours a day seven days a week as required.</p> <p>On 04/30/24 at 3:50 P.M., and on 05/01/24 at 10:38 A.M. an interview with Regional Administrator #650 verified the facility was without a RN on the days listed above and verified the PBJ Report was accurate.</p> <p>49774</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure clear instructions were in place for the use of narcotic pain medication and did not ensure non-pharmacological interventions were attempted prior to the administration of pain medication. This affected two residents (#53 and #64) of five residents reviewed for unnecessary medications. The facility census was 101.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including heart failure, muscle wasting, hypertension, diabetes, depression, and insomnia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 was cognitively intact. She required partial to moderate assistance for eating and oral hygiene and was dependent for toileting, showering, and personal hygiene.</p> <p>Review of the physician's orders for April 2024 revealed an order for Acetaminophen 325 milligrams (mg) (analgesic) every four hours as needed (prn) for general discomfort and Hydrocodone (a narcotic pain medication) 325 mg every six hours prn for pain.</p> <p>Review of the medication administration record (MAR) for February 2024 revealed Resident #53 received one dose of Hydrocodone for a pain level of eight on 02/01/24, one dose for a pain level of six on 02/02/24, one dose for a pain level of six on 02/06/24, one dose for a pain level of four on 02/06/24, one dose for a pain level of four on 02/08/24, one dose for a pain level of five on 02/08/24, one dose for a pain level of four on 02/09/24, one dose for a pain level of five on 02/10/24, one dose for a pain level of six on 02/10/24, two doses for a pain level of four on 02/12/24, one dose for a pain level of four on 02/21/24, one dose for a pain level of four on 02/22/24, one dose for a pain level of five on 02/23/24, one dose for a pain level of eight on 02/24/24, one dose for a pain level of four on 02/25/24, one dose for a pain level of five on 02/26/24, one dose for a pain level of four on 02/27/24, one dose for a pain level of five on 02/28/24, and one dose on seven on 02/29/24. She received one dose of Acetaminophen for a pain level of four on 02/08/24, one dose for a pain level of four on 02/15/24, one dose for a pain level of two on 02/16/24, one dose for a pain level of zero on 02/18/24, and one dose for a pain level of five on 02/28/24.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MAR for March 2024 revealed Resident #53 received one dose of Hydrocodone for a pain level of two on 03/01/24, one dose for a pain level of four on 03/01/24, one dose for a pain level of five on 03/03/24, one dose for a pain level of five on 03/04/24, one dose for a pain level of eight on 03/05/24, one dose for a pain level of four on 03/07/24, one dose for a pain level of six on 03/07/24, one dose for a pain level of four on 03/08/24, one dose for a pain level of five on 03/09/24, one dose for a pain level of eight on 03/10/24, one dose for a pain level of four on 03/10/24, one dose for a pain level of five on 03/11/24, one dose for a pain level of eight on 03/12/24, one dose for a pain level of six on 03/13/24, one dose for a pain level of four on 03/13/24, one dose for a pain level of four on 03/15/24, one dose for a pain level of four on 03/16/24, one dose for a pain level of one on 03/16/24, one dose for a pain level of seven on 03/17/24, one dose for a pain level of six on 03/19/24, one dose for a pain level of four on 03/19/24, one dose for a pain level of eight on 03/21/24, one dose for a pain level of six on 03/21/24, one dose for a pain level of five on 03/22/24, two doses for a pain level of five on 03/26/24, one dose for a pain level of five on 03/27/24, one dose for a pain level of eight on 03/28/24, one dose for a pain level of four on 03/30/24, one dose for a pain level of five on 03/30/24, and two doses for a pain level of four on 03/31/24.</p> <p>Review of the MAR for April 2024 revealed Resident #53 received one dose of Hydrocodone for a pain level of four on 04/02/24, one dose for a pain level of five on 04/03/24, one dose for a pain level of five on 04/04/24, one dose for a pain level of nine on 04/06/24, two doses for a pain level of four on 04/08/24, two doses for a pain level of five on 04/09/24, one dose for a pain level of six on 04/11/24, one dose for a pain level of five on 04/11/24, one dose for a pain level of four on 04/12/24, one dose for a pain level of seven on 04/13/24, one dose for a pain level of four on 04/13/24, one dose for a pain level of five on 03/13/24, one dose for a pain level of four on 04/14/24, one dose for a pain level of five on 03/15/24, one dose for a pain level of four on 03/16/24, one dose for a pain level of six on 04/17/24, one dose for a pain level of four on 04/17/24, one dose for a pain level of four of 04/18/24, one dose for a pain level of four on 04/19/24, one dose for a pain level of four on 04/20/24, one dose for a pain level of six on 04/21/24, one dose for a pain level of four on 04/22/24, one dose for a pain level of five on 04/22/24, one dose for a pain level of four on 04/23/24, one dose for a pain level of five on 04/24/24, one dose for a pain level of seven on 04/25/24, one dose for a pain level of three on 03/27/24, one dose for a pain level of four on 04/28/24, and one dose for a pain level of four on 04/29/24.</p> <p>Review of the MAR for April 2024 revealed resident #53 received one dose of Acetaminophen for a pain level of four on 04/01/24, one dose for a pain level of two on 04/04/24, one dose for a pain level of five on 04/05/24, one dose for a pain level of four on 04/08/24, one dose for a pain level of four on 04/17/24, one dose for a pain level of three on 04/18/24, one dose for a pain level of two on 04/19/24, one dose for a pain level of four on 04/21/24, and one dose for a pain level of here on 04/22/24.</p> <p>Review of the progress notes dated 02/01/24 through 04/30/24 revealed no documented evidence non-pharmacological interventions were attempted prior to the administration of pain medications on 03/02/24, 03/07/24, 03/11/24, 03/16/24, 03/28/24, 03/30/24, 03/31/24, 04/08/24, 04/12/24, 04/16/24, and 04/29/24.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/30/24 at 10:52 A.M. with Licensed Practical Nurse (LPN) #593 revealed non-pharmacological interventions should be attempted and documented in the progress notes prior to administering prn pain medications. She revealed she used her nursing judgement to determine whether to administer Acetaminophen or narcotic pain medicine; there was no guidance or scale used to reference when to administer narcotic pain medications.</p> <p>2. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including congestive heart failure (CHF), muscle weakness, depression, anxiety, chronic kidney disease, and dementia.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #64 was severely cognitively impaired. She required supervision for eating, partial to moderate assistance for oral care and substantial to maximum assistance for toileting, showering, and personal hygiene.</p> <p>Review of physician's orders for April 2024 revealed an order for Tramadol (a narcotic pain medication) 50 mg every four hours prn for pain and Acetaminophen 325 mg every four hours prn for pain, to be given with Tramadol.</p> <p>Review of the MAR for February 2024 revealed Resident #64 received one dose of Tramadol for a pain level of four on 02/09/24, one dose for a pain level of six on 02/10/24, one dose for a pain level of two on 02/11/24, one dose for a pain level of four on 02/12/24, one dose for a pain level of three on 02/14/24, one dose for a pain level of three on 02/16/24, one dose for a pain level of seven on 02/19/24, one dose for a pain level of three on 02/20/24, one dose for a pain level of four on 02/20/24, two doses for a pain level of three on 02/21/24, one dose for a pain level of four on 02/22/24, one dose for a pain level of five on 02/22/24, one dose for a pain level of three on 02/23/24, one dose for a pain level of zero on 02/24/24, one dose for a pain level of eight on 02/28/24. The resident received one dose of Acetaminophen for a pain level of five on 02/18/24, one dose for a pain level of five on 02/19/24, one dose for a pain level of five on 02/21/24, one dose for a pain level of five on 02/22/24, one dose for a pain level of zero on 02/23/24, one dose for a pain level of three on 02/24/24, and one dose for a pain level of zero on 02/28/24.</p> <p>Review of the MAR for March 2024 revealed Resident #64 received one dose of Tramadol for a pain level of four on 03/02/24, one dose for a pain level of zero on 03/04/24, one dose for a pain level of three on 03/05/24, one dose for a pain level of three on 03/07/24, one dose for a pain level of four on 03/08/24, one dose for a pain level of six on 03/09/24, one dose for a pain level of six on 03/15/24, one dose for a pain level of six on 03/07/24, one dose for a pain level of two on 03/24/24 and one dose for a pain level of zero on 03/28/24. The resident received one dose of Acetaminophen for a pain level of zero on 03/04/24, one dose for a pain level of five on 03/08/24, one dose for a pain level of two on 03/09/24, one dose for a pain level of three on 03/09/24, one dose for a pain level of two on 03/10/24, one dose for a pain level of zero on 03/10/24, one dose for a pain level of two on 03/11/24, one dose for a pain level of four on 03/11/24, one dose for a pain level of five on 03/15/24, one dose for a pain level of two on 03/08/24, one dose for a pain level of two on 03/24/24 ,and one dose for a pain level of two on 03/25/24.</p> <p>Review of the progress notes dated 02/01/24 through 03/31/24 revealed no documented evidence non-pharmacological interventions were attempted prior to the administration of pain medications on 02/08/24, 02/09/24, 02/10/24, 02/14/24, 02/19/24, 03/26/24, and 03/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/30/24 at 10:52 A.M. with Licensed Practical Nurse (LPN) #593 revealed non-pharmacological interventions should be attempted and documented in the progress notes prior to administering prn pain medications. She revealed she used her nursing judgement to determine whether to administer Acetaminophen or narcotic pain medicine; there was no guidance or scale used to reference when to administer narcotic pain medications.</p> <p>Review of the facility policy titled Pain Management, dated August 2018, revealed the facility would use a 1-10 scale with 10 being the worst, to determine the intensity of pain. In addition, the facility would attempt non-pharmacological pain reduction techniques prior to administering pain medications in an attempt to lower doses of medications and risk of adverse consequences.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Liberty Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on record review, interview and facility policy review, the facility failed to ensure appropriate diagnoses and rationale for prescribed medications. This affected two residents (#22 and #53) of five reviewed for unnecessary medications. The facility census was 101.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including dementia, depression, diabetes, breast cancer, and Parkinson's disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was moderately cognitively impaired. She required set up help for eating, supervision for oral hygiene and personal hygiene, and substantial assistance for toileting and showering.</p> <p>Review of the physician's orders for April 2024 revealed an order for Klonopin (a sedative used to treat seizures, panic disorder, and anxiety) 0.5 milligrams (mg) two times per day (BID) for dementia. The order began on 09/25/23.</p> <p>Interview on 05/01/24 at 12:53 P.M. with Registered Nurse (RN) #648 verified Klonopin was not approved for the use of dementia and was contraindicated for Resident #22.</p> <p>2. Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including heart failure, muscle wasting, hypertension, diabetes, depression, and insomnia.</p> <p>Review of the Quarterly MDS assessment dated [DATE] revealed Resident #53 was cognitively intact. She required partial to moderate assistance for eating and oral hygiene and was dependent for toileting, showering, and personal hygiene.</p> <p>Review of the physician's orders for April 2024 revealed an order for Ativan (antianxiety) 0.5 mg one tablet by mouth at bedtime for restlessness or anxiety. The order began on 02/27/24.</p> <p>Interview on 05/01/24 at 12:37 P.M. with RN #648 Revealed there was no diagnosis for the use of Ativan for Resident #53.</p> <p>Review of the facility policy titled Psychotropic Medications, dated October 2022, revealed the facility would ensure residents received only medications to treat assessed and documented medical conditions.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441</p> <p>Based on observation, record review, interview, facility policy review and Centers for Disease Control and Prevention (CDC) guidance review, the facility failed to ensure Contact Precautions were implemented as ordered for Resident #22. This affected one resident (#22) of five residents reviewed for infection control and had the potential to affect all 50 additional residents (#3, #4, #7, #8, #10, #11, #13, #14, #16, #17, #19, #23, #24, #26 #29, #30, #31, #33, #37, #39, #41, #42, #43, #48, #50, #53, #55, #56, #58, #59, #60, #62, #63, #65, #68, # 69, #71, #75, #76, #79, #80, #85, #88, #96, #255, #256, #257, #305, #307 and #405) residing on the East Wing. The facility census was 101.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including dementia, depression, diabetes, breast cancer, and Parkinson's disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was moderately cognitively impaired. She required set up help for eating, supervision for oral hygiene and personal hygiene, and substantial assistance for toileting and showering. The resident was always incontinent of bowel and bladder.</p> <p>Review of the physician's orders for April 2023 revealed Resident #22 was on Contact Precautions for Escherichia coli (E. coli), a bacteria found in the environment, foods, and intestines, and extended-spectrum beta-lactamases (ESBLs), enzymes produced by some bacteria that make them resistant to many antibiotics in the urine. The order began on 04/23/24.</p> <p>Observation on 04/30/24 at 11:01 A.M. revealed a sign on Resident #22's door that states enhanced barrier precautions (EBP) were in place. Resident #22's roommate was on EBP. There was no sign on Resident #22's door for Contact Precautions.</p> <p>Observation on 04/30/24 at 10:16 AM revealed Resident #22 was up in a wheelchair in the common area resting.</p> <p>Interview on 04/30/24 at 11:01 A.M. with Licensed Practical Nurse (LPN) #601 confirmed Resident #22 was on Contact Precautions for ESBL and E. coli. She confirmed Resident #22 was not in her room and believed it was because the isolation had ended. She confirmed the order for Contact Precautions was still active.</p> <p>Review of the facility policy titled Contact Precautions, dated March 2020, revealed the facility would use contact precautions for residents known or suspected to have infectious diseases transmitted by direct resident contact or contact with items in the resident's environment. Contact Precautions will be used in addition to standard precautions for residents with specific infections that could be transmitted by direct or indirect contact.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the CDC guidance revealed Contact Precautions require the use of gown and gloves on every entry into the resident's room, regardless of the level of care being provided to the resident. The resident is given dedicated equipment and placed in a private room. When private rooms are not available, some residents (e.g., residents with the same pathogen) may be roomed together. Residents on Contact Precautions are recommended to be restricted to their rooms except for medically necessary care, including restriction from participation in group activity. Contact Precautions are generally intended to be limited and, when implemented, should include a plan for discontinuation or de-escalation. EBP requires the use of gowns and gloves only for high-contact resident care activities. Residents are not restricted to their rooms and do not require placement in a private room. EBP also allows residents to participate in group activities. EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of the residents stay in the facility or until resolution of a wound or discontinuation of the indwelling medical device that placed them at higher risk.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808</p> <p>Based on medical record review and staff interview, the facility failed to provide a pneumococcal vaccination after consent was provided for Resident #77. This affected one resident (#77) of five reviewed for immunizations. The facility census was 101.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #77 revealed an admitted [DATE] with diagnoses including major depressive disorder, anxiety, and muscle weakness.</p> <p>Review of Resident #77's pneumococcal polysaccharide vaccine (PPSV 23) consent form revealed Resident #77 agreed to receive the vaccination on 03/07/23.</p> <p>Further review of the medical record for Resident #77 revealed there was no documentation that the vaccination had been administered.</p> <p>On 05/02/24 at 11:04 A.M., interview with Corporate Quality Assurance (QA) Nurse #648 verified there was no evidence Resident #77 received the pneumococcal polysaccharide vaccine.</p>