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

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's self-reported incident (SRI) investigation, and interview, the facility failed to maintain complete and accurate records of transactions for resident funds accounts. This affected nine residents (#16, #45, #49, #59, #63, #68, #124, #125, #126) out of 15 residents reviewed for resident funds. The facility census was 101.Findings include:1. Review of the medical record for Resident #16 revealed an admission date of [DATE] with diagnoses including unspecified head injury, hyperlipidemia, type two diabetes mellitus, and major depressive disorder.Review of the resident trust transaction history for Resident #16 revealed there were cash withdrawals of $15.00 on [DATE], $6.00 on [DATE], and $6.00 on [DATE] with no receipts available for these transactions.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had no cognitive impairment.2. Review of the medical record for Resident #45 revealed an admission date of [DATE] with diagnoses including Parkinson's disease, type two diabetes mellitus, anxiety disorder, and major depressive disorder.Review of the quarterly MDS assessment dated [DATE] revealed Resident #45 had no cognitive impairment.Review of the resident trust transaction history for Resident #45 revealed there was a cash withdrawal of $10.00 on [DATE] with no receipt available for this transaction.3. Review of the medical record for Resident #49 revealed an admission date of [DATE] with diagnoses including Multiple Sclerosis, type two diabetes mellitus, depression, and hypertension.Review of the resident trust transaction history for Resident #49 revealed there was a cash withdrawal of $30.00 on [DATE] with no receipt available for this transaction.Review of the annual MDS assessment dated [DATE] revealed Resident #49 had no cognitive impairment.4. Review of the medical record for Resident #59 revealed an admission date of [DATE] with diagnoses including hypothyroidism, hyperlipidemia, bipolar disorder, dementia, mild cognitive impairment, and major depressive disorder.Review of the resident trust transaction history for Resident #59 revealed there were cash withdrawals of $5.00 on [DATE], $5.00 on [DATE], and $5.00 on [DATE] with no receipts available for these transactions.Review of the quarterly MDS assessment dated [DATE] revealed Resident #59 had no cognitive impairment.5. Review of the medical record for Resident #63 revealed an admission date of [DATE] with diagnoses including anxiety disorder, major depressive disorder, hypothyroidism, hypertension, and cerebral infarction.Review of the resident trust transaction history for Resident #63 revealed there were cash withdrawals of $360.00 on [DATE], $20.00 on [DATE], and $90.00 on [DATE] with no receipts available for these transactions.Review of the quarterly MDS assessment dated [DATE] revealed Resident #63 had no cognitive impairment.6. Review of the medical record for Resident #68 revealed an admission date of [DATE] with diagnoses including anxiety disorder, major depressive disorder, hyperlipidemia, and hypertension.Review of the resident trust transaction history for Resident #68 revealed there was a cash withdrawal of $10.00 on [DATE] with no receipt available for this transaction.Review of the annual MDS assessment dated [DATE] revealed Resident #68 had no cognitive impairment.7. Review of the closed medical record for Resident #124 revealed an admission date of [DATE] with diagnoses including Parkinson's disease, dementia with agitation, hypertension, (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	type two diabetes mellitus, and Alzheimer's disease. Resident #124 expired on [DATE].Review of the resident trust transaction history for Resident #124 revealed there was a cash withdrawal of $100.00 on [DATE] with no receipt available for this transaction.Review of the quarterly MDS assessment dated [DATE] revealed Resident #124 had severe cognitive impairment.8. Review of the closed medical record for Resident #125 revealed an admission date of [DATE] with diagnoses including major depressive disorder, dementia with anxiety, amnesia, and anxiety disorder. Resident #125 discharged on [DATE].Review of the resident trust transaction history for Resident #125 revealed there was a cash withdrawal of $140.00 on [DATE] with no receipt available for this transaction.Review of the discharge MDS assessment dated [DATE] revealed Resident #125 had severe cognitive impairment.9. Review of the closed medical record for Resident #126 revealed an admission date of [DATE] with diagnoses including major depressive disorder, type two diabetes mellitus, hyperlipidemia, and cerebral infarction. Resident #126 discharged on [DATE].Review of the resident trust transaction history for Resident #126 revealed there were cash withdrawals of $10.00 on [DATE] and $10.00 on [DATE] with no receipts available for these transactions.Review of the discharge MDS assessment dated [DATE] revealed Resident #126 had no cognitive impairment.Review of the facility's investigation of SRI tracking number 271333, opened on [DATE], revealed nine residents (#16, #45, #49, #59, #63, #68, #124, #125, #126) had cash withdrawals from their accounts, which were managed by the facility, with no receipt available for those withdrawals totaling $822.00. The Administrator interviewed the alleged perpetrator during their investigation of the incident, and the alleged perpetrator stated she knew there would be errors claiming health issues were to blame for the errors. During their investigation, the facility was unable to locate any receipts confirming those withdrawals occurred. There was no evidence to support misappropriation; however, the lack of receipts for documented withdrawals demonstrated a lack of a complete and accurate accounting of resident funds managed by the facility.On [DATE] at 11:53 A.M., an interview with the Administrator stated they investigated the incident for misappropriation and could not prove that the funds were misappropriated. The Administrator confirmed their investigation identified there were 16 cash withdrawals from resident accounts with no receipts documented for those transactions. She stated when a former employee identified as the alleged perpetrator was questioned, that employee claimed there were possibly bookkeeping mistakes due to underlying health issues, and she denied taking any money from resident accounts. The Administrator stated they replaced the funds in question out of good faith despite not being able to prove the funds were misappropriated.

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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.

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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.

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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, medical record review, policy review and interview, the facility failed to identify and monitor bruises for one (Resident #76) of 42 residents observed for non-pressure related skin concerns and failed to implement bowel protocol and physician orders for Resident #85 and failed to change Resident #105's peripherally inserted central catheter (PICC) line dressing changed weekly as ordered by the physician. This affected two residents (#76 and 3105) of five residents reviewed for medication use. The facility census was 101. Findings include:1. On 03/02/26 at 10:53 A.M., ecchymotic (bruised) areas were observed on Resident #76's left upper arm and right wrist. Resident #76 was unable to provide any information related to the bruises. Review of Resident #76's medical record revealed diagnoses including displaced fracture of the base of the neck of the right femur (thigh bone), presence of a right artificial hip joint, repeated falls, and dementia. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #76 was severely cognitively impaired. No documentation was able to be located related to the bruises. On 03/03/26 at 2:05 P.M., Licensed Practical Nurse (LPN) #560 stated she was unaware of the bruises, and there was no documentation in the medical record regarding the bruises. During observations of Resident #76 with LPN #560 at that time, it was verified Resident #76 had bruises on the left upper extremity, right upper extremity, and right wrist. Review of a nursing note dated 03/03/26 at 2:33 P.M. indicated Resident #76 was noted to have small bruises to bilateral upper arms and the right wrist. The right upper arm bruise measured 2.5 centimeters (cm) by 1.5 cm in diameter. All bruises were dark and purple. Resident #76's daughter was notified and indicated she was already aware of the bruises stating she figured Resident #76 must have bumped them on the side rail. The physician was notified of the incident. Review of a nursing note dated 03/04/26 at 9:51 A.M. indicated the bruising was reassessed with a registered nurse (RN). Resident #76's son-in-law was present during the assessment. Resident #76 was observed with a light purple quarter-sized area to the left bicep region and a light purple/green half-dollar sized bruise to the right bicep region. The areas of bruising to both arms were directly in line with edges of the underlying Hoyer (mechanical lift) pad in the Broda chair. The area of bruising noted to the right wrist was light/medium purple and presented as petechiae (tiny spots of bleeding). The son-in-law reported Resident #76 had a history of bruising related to very fragile skin. The note indicated a plan to implement a larger Hoyer pad for transfers. 2. Review of Resident #85's medical record revealed diagnoses including chronic pain and vascular dementia. Review of physician's orders dated 02/16/26 revealed if Resident #85 did not have a bowel movement in 48 hours, four ounces of high fiber juice or prune juice was to be administered. Results were to be documented. If there were no results from the high fiber juice, 30 milliliters of Milk of Magnesia (laxative) was to be administered. If there were no results from the Milk of Magnesia, one Dulcolax suppository (laxative) was to be administered after an abdominal evaluation. An admission MDS dated [DATE] indicated Resident #85 was severely cognitively impaired. Resident #85 was assessed as always being incontinent of bowel. Review of Resident #85's bowel movement records revealed bowel movements were recorded on 02/17/26, 02/22/26 and 02/24/26. As of the morning of 03/03/26, there was no evidence orders for the high fiber juice, Milk of Magnesia or Dulcolax suppository were implemented as ordered. On 03/03/26 at 3:10 P.M., Certified Nursing Assistant (CNA) #521 stated Resident #85's bowels moved that day. Resident #85 was incontinent and dependent on staff for toileting hygiene. On 03/04/26 at 10:23 A.M., Corporate Quality Assurance (QA) Registered Nurse (RN) #499 verified, after reviewing bowel movement records for February and March 2026 medication administration records, staff did not implement orders for bowel protocol. On 03/05/26 at 11:35 A.M., RN #589 stated a report was run on a daily basis for those residents who did not have a bowel movement recorded for two full days and a list was provided to the floor nurses. The floor nurses were expected to implement the facility's bowel protocol. RN #589 verified there was no evidence of the bowel protocol/orders being (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed for Resident #85.Review of the facility's Bowel Movement Protocol Policy (dated May 2025) revealed the unit nurse would monitor the bowel movement records and bowel alerts and would follow the facility bowel protocol unless a specific bowel protocol was ordered/care planned for a specific resident. Night shift nurses were responsible for listing all residents who had not had a bowel movement in 48 hours based on the clinical alerts in the electronic health record. The list was to be provided to the dayshift nurse who would administer high fiber juice with the morning medication pass and would document any results. If no results that afternoon the dayshift nurse would complete an abdominal assessment including assessment of bowel sounds. If bowel sounds were present, the nurse was to administer Milk of Magnesia with the afternoon (4:00 P.M.) medication pass and document the results. If there were no results from the Milk of Magnesia, the night nurse was to complete an abdominal assessment including bowel sounds and administer a Dulcolax rectal suppository with the early morning med pass (6:00 A.M.) If there were no results from the suppository, the day shift nurse was to do an abdominal assessment and administer a fleets enema or soap suds enema by the afternoon med pass. If there were no results from the enema within one hour, the physician/practitioner would be notified for further orders. 3. Record review of Resident #105 admitted on [DATE] with a diagnoses of encounter for orthopedic aftercare following surgical amputation, acquired absence of other right toe(s), other acute osteomyelitis, right ankle and foot, cellulitis of right lower limb, vitamin D deficiency, type two diabetes mellitus with diabetic neuropathy, type two diabetes mellitus with other skin complications, non-pressure chronic ulcer of other part of right foot with unspecified severity, muscle weakness (generalized), difficulty in walking, not elsewhere classified, mixed hyperlipidemia, essential (primary) hypertension, unspecified contact dermatitis due to plants, except food, other specified symptoms and signs involving the circulatory and respiratory systems, morbid (severe) obesity due to excess calories, mild intermittent asthma, polyneuropathy, local infection of the skin and subcutaneous tissue. Review of the physician orders revealed an order dated 02/24/26 to change Resident #105's PICC line dressing weekly on Mondays (start 03/02/26).Observation on 03/02/26 at 9:59 A.M. of Resident #105's PICC line dressing was dated 02/23/26. The PICC line dressing was observed with dried blood under the sterile dressing. Observation on 03/04/26 at 2:20 P.M. revealed Resident #105's PICC line dressing was dated for 02/23/26 with dried blood under the dressing.Interview on 03/04/26 at 8:53 A.M. with LPN #536 confirmed Resident #105's PICC line dressing was dated 02/23/26 and had not been changed on 03/02/26 per physician orders.

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

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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 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 observations, medical record review, and interview, the facility failed to implement pressure-relieving interventions for one (Resident #76) of five residents reviewed for pressure ulcers. The facility census was 101.Findings include:Review of Resident #76's medical record revealed diagnoses including chronic anemia, dementia, and right hip fracture. Resident #76 was admitted to the facility on [DATE] with an unstageable pressure ulcer (full-thickness wound whose depth cannot be determined because it is obscured by slough, eschar, or a non-removable dressing) to the right heel. Slough is dead tissue in the wound. Eschar is necrotic tissue. On 06/27/25, an order was written to offload heels in bed for preventative skin care. A plan of care initiated 07/07/25 indicated Resident #76 had potential/actual impairment to skin integrity related to incontinence, muscle wasting and atrophy, muscle weakness, fracture, hypertension, hypothyroidism, dementia, deep vein thrombosis, depression and anemia. Interventions included identifying potential causative factors and eliminating/resolving them where possible. On 08/11/25 an order was written for a wedge cushion under her feet when in the Broda chair. A wound assessment dated [DATE] indicated the right heel pressure ulcer was resolved. The orders for the wedge cushion under the feet in the Broda chair and offloading the heels in the bed continued. On 03/02/2026 at 10:53 A.M., Resident #76 was observed sitting in a Broda chair in her room. There were two signs posted on the walls (one above the bed and one by the bathroom door) to apply a boot when up in the wheelchair. Resident #76's left foot was resting on the foot of the Broda chair with no wedge observed. On 03/03/26 at 10:15 A.M., Certified Nursing Assistant (CNA) #623 revealed there was a boot on Resident #76's right foot while sitting in the Broda chair but there was no wedge or devices to alleviate pressure on the left heel which was resting on the foot of the chair. On 03/03/26 at 2:05 P.M., Licensed Practical Nurse (LPN) #560 verified Resident #76, who was lying in bed, had a boot on the right foot but her left foot was resting on the surface of the mattress.

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, record review, interview and facility policy review, the facility failed to implement appropriate infection control protocols during medication administration for Resident #19 and failed to wear appropriate personal protective equipment (PPE) while administering intravenous (IV) medication to Resident #105. This affected two residents (#19 and #105) out of four residents reviewed for infection control. The facility census was 101.Findings include:1. Review of the medical record for Resident #19 revealed an admission date of 10/25/24 with diagnoses including adjustment disorder, anxiety disorder, type two diabetes mellitus, altered mental status, and dementia with agitation.Review of the care plan revised 11/25/25 revealed Resident #19 had impaired cognitive function and thought processes related to impaired decision making and dementia. Interventions included administering medications as ordered and monitoring for effectiveness.On 03/03/26 at 8:49 A.M., an observation revealed Registered Nurse (RN) #559 was administering medications to Resident #19. The pills were in a small plastic cup, and RN #559 was using a plastic spoon to remove the pills from the plastic cup one at a time to administer the medications to Resident #19. While doing so, RN #559 dropped one pill onto the blanket on Resident #19's lap. RN #559 picked the pill up off the blanket with her bare hand, placed the pill back in the plastic cup with the other pills, then used the plastic spoon to administer the remainder of Resident #19's pills.On 03/03/26 at 8:50 A.M., an interview with RN #559 verified she dropped one pill, picked it up with her bare hand, put it back in the plastic cup with other pills, and administered the dropped pill and remaining pills to Resident #19. RN #559 said picking the pill up off the blanket was a reflex and that was not proper protocol.2. Review of Resident #105's medical record revealed diagnoses including type two diabetes mellitus with a foot ulcer, local infection of the skin and subcutaneous tissue, and acquired absence of right toe(s) and osteomyelitis (serious bone infection) of the right ankle and foot. On 02/07/26 an order was written for Enhanced Barrier Precautions (EBP) during high contact resident care activities while Resident #105 had an indwelling medical device or chronic wound. On 02/24/26, an order was written for vancomycin HCl (antibiotic) 1500 milligrams (mg) IV in the mornings related to osteomyelitis. On 02/24/26, an order was written to change the Peripherally Inserted Central Catheter (PICC)/midline cap and dressing weekly every Monday. On 03/03/26 at 8:20 A.M., Licensed Practical Nurse (LPN) #536 was observed administering the vancomycin to Resident #105. No gown was worn during the administration of the vancomycin through a PICC. On 03/03/26 at 8:24 A.M., LPN #536 verified she did not wear a gown while administering the vancomycin. Review of the facility's EBP policy (dated March 2024) revealed EBP was indicated for indwelling medical devices including central line IV access. This deficiency represents non-compliance investigated under Master Complaint Number 2724622 and Complaint Number 2715174.