STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366195	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beeghly Oaks Center for Rehabilitation & Healing	6505 Market Street Youngstown, OH 44512

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to provide adequate wound care including wound assessments and treatments as ordered. This affected one resident (Resident #61) out of three residents reviewed for wound care. The facility identified 23 residents (Residents #2, #6, #18, #19, #24, #30, #31, #32, #33, #37, #38, #39, #45, #56, #60, #61, #67, #91, #95, #96, #99, #100 and #101) with wounds. The facility census was 102.Findings include:Review of medical record for Resident #61 revealed an admission date of 05/04/26 and his diagnoses included diabetes, chronic renal failure requiring dialysis, orthopedic aftercare following surgical amputation, gangrene (blood flow to specific area was compromised leading to tissue death and potential for amputation), absence of left hand, absence of right leg above the knee, and absence of left leg above the knee. Review of care plan dated 05/06/26 revealed Resident #61 had actual skin impairment related to a left-hand surgical wound, and gangrene to the right hand with wound to the right wrist. Interventions included keeping the skin clean and dry, using caution during transfers to prevent striking arms or hand against any sharp or hard surface, and weekly treatment documentation to include measurements. There was nothing in the care plan regarding completion of treatments to the right hand or wrist. Review of progress note dated 05/18/26 completed by Orthopedic Physician Assistant (OPA) #742 revealed Resident #61 was evaluated due to status post left wrist disarticulation (surgical removal of the hand at the wrist joint). His right hand continued to be gangrenous but remained stable. OPA #742 revealed to continue twice a day dressing changes to his right upper extremity, monitor for signs of infection and call with any concerns. Review of June 2026 physician orders and June 2026 Treatment Administration Record (TAR) revealed Resident #61 had an order dated 05/11/26 to cleanse right hand areas with warm soapy water and dial soap, pat dry, make sure area was fully dry before applying dressing, apply light application of bacitracin ointment over the wound only, do not put bacitracin (topical antibiotic ointment) over the surrounding tissue, apply xeroform (a sterile, non-adhering wound dressing made of fine-mesh gauze impregnated with petroleum jelly and an antibacterial agent) to open areas, cover with four-by-four gauze and wrap with kerlix (gauze wrap) every shift (6:00 A.M. and 6:00 P.M.) and as needed. The treatment was not signed as completed in the TAR on 06/06/26 at 6:00 A.M. On 06/14/26 at 6:00 P.M, Registered Nurse (RN) #629 signed off the above treatment as completed; however, on 06/15/26 at 6:00 A.M, Licensed Practical Nurse (LPN) #603 made a treatment administration note which specified the resident's treatment was not completed, following shift informed with no reason provided as to why it was not completed. On 06/15/26 at 6:00 P.M., RN #615 signed off the above treatment as completed as ordered; on 06/16/26 at 6:00 A.M., LPN #616 signed off the above treatment as completed as ordered; and on 06/16/26 at 6:00 P.M., RN #629 signed off the above treatment as completed as ordered. Resident #61 had a physician order dated 05/19/26 to cleanse surgical incision to left upper extremity with normal saline, apply abdominal (ABD) pad, and wrap with gauze wrap daily and as needed. The TAR revealed on 06/15/26 at 6:00 A.M., LPN #603 made a treatment administration note which specified the Resident #61's treatment was not completed, following shift informed with no reason provided as to why it was not completed. There was no further documentation the treatment was (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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed on 06/15/26. On 06/16/26, LPN #616 signed off the above treatment as completed as ordered. There was also a physician order dated 05/07/26 for the nurse to evaluate his right-hand wound including assessing for drainage, signs of infection, necrotic tissue, odor, issues with surrounding tissue and pain every shift. The TAR revealed on 06/14/26 at 6:00 P.M., RN #629 signed off she had assessed his wound. On 06/15/26 at 6:00 A.M., LPN #603 made a treatment administration note which specified the resident's wound was not assessed stating, not completed, following shift informed with no reason provided as to why it was not completed. On 06/15/26 at 6:00 P.M., RN #615 signed off she had assessed his wound; on 06/16/26 at 6:00 A.M., LPN #616 signed off she had assessed his wound; and on 06/16/26 at 6:00 P.M., RN #629 signed off she had assessed his wound. Review of Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was cognitively intact. He was dependent on staff for all his activities of daily living (ADLs) and had a surgical wound. Review of the After Visit Summary dated 06/08/26 completed by OPA #742 revealed Resident #61 had a follow-up consult and she recommended doing daily skin checks and a dressing change to the left upper extremity. She also recommended twice daily dressing changes to the right upper extremity of cleansing the areas to the right hand with warm soapy water and dial soap, pat dry, make sure area fully dry before applying dressing, apply light application of bacitracin ointment over the wound only, do not put bacitracin over the surrounding tissue, apply xeroform to open areas, cover with four-by-four gauze and wrap with kerlix. She also recommended monitoring for signs of infection including redness, warmth, drainage, foul smell, fevers or chills. Review of the Skin Only Evaluation dated 06/09/26 completed by LPN #642 revealed Resident #61 had an area to his right wrist that measured 3.0 centimeters (cm) length, 1.6 cm width, and 0.1 cm depth. There were no other descriptions and the note specified to continue treatment as ordered. Review of care plan last revised 06/10/26 revealed Resident #61 had an old bilateral above the knee amputation and new hand amputation (left). Interventions included checking and documenting on the wound daily for signs of infection, monitoring for excessive wound drainage, and changing the dressing as orderedReview of the Skin Only Evaluation dated 06/16/26 completed by LPN #642 revealed Resident #61 had an area to his right wrist measuring 3.0 cm length, 1.6 cm width, and 0.1 cm depth (same measurements as 06/09/26). There were no other descriptions and the note specified to continue treatment as ordered. This assessment was struck out due to a data entry error by Assistant Director of Nursing (ADON)/LPN #741 on 06/17/26 at 1:01 P.M.Interview on 06/17/26 at 10:20 A.M. with Ombudsman #737 revealed Resident #61 had a concern that the facility was not completing his wound care as ordered. Observation and interview on 06/17/26 at 11:21 A.M. with Resident #61 revealed he was lying in bed, and he did not have a wound dressing to his left upper extremity. His fingers on his right hand were gangrenous, and a gauze wrap was covering his hand and wrist area. The dressing to his right hand was dated 06/14/26 at 3:00 P.M. with RN #682's initials. Resident #61 stated his right-hand dressing was to be completed twice a day as ordered per OPA #742 and that the last time they had changed it was on 06/14/26 at 3:00 P.M. (three days prior). He complained the nurses frequently did not complete his wound dressing changes and was concerned he was going to lose his hand because they were not following the physician order. He also stated they do not do the treatment to his left upper extremity as ordered as the last time it was done was also on 06/14/26 at 3:00 P.M. by RN #682. The dressing to his left upper extremity had since fallen off on 06/15/26. Observation and interview on 06/17/26 at 11:44 A.M. with ADON/LPN #741 verified the dressing to Resident #61's right hand was dated 06/14/26 at 3:00 P.M. and the dressing was to be completed twice a day per physician order. She verified per the TAR, the treatment to his right hand was blank on 06/06/26 at 6:00 A.M.; on 06/14/26 at 6:00 P.M., RN #629 had signed off the above treatment as completed; on 06/15/26 at 6:00 A.M., LPN #603 made a treatment administration note which specified the treatment was not completed, following shift informed; on 06/15/26 at 6:00 P.M., RN #615 signed off the above treatment as completed; on 06/16/26 at 6:00 A.M., LPN #616 signed off the above treatment as completed; and on 06/16/26 at 6:00 P.M., RN #629 signed off the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above treatment as completed. She verified the documentation was inaccurate as his treatment had not been done since 06/14/26 at 3:00 P.M. per the dated dressing. Also, she verified he did not have a dressing on his left upper extremity. Interview on 06/17/26 at 12:05 P.M. and 06/18/26 at 9:10 A.M. with Director of Nursing (DON) verified Resident #61's dressing to his right hand was last changed on 06/14/26 at 3:00 P.M., and it was to be changed twice a day as ordered by OPA #742. She confirmed the nurses had documented the dressing was changed and when they had not changed it. She also verified there was a physician order to evaluate his wound every shift, and the nurse had signed off that this was completed on 06/14/26 at 6:00 P.M., 06/15/26 at 6:00 P.M., and 06/16/26 at 6:00 A.M. and 6:00 P.M. She verified the wound was not assessed as ordered since the dressing dated 06/14/26 at 3:00 P.M. was never removed. She verified the wound was not assessed from 06/14/26 3:00 P.M. to 06/17/26 at 3:55 P.M. (three days). She verified the Skin Only Evaluation dated 06/16/26 completed by LPN #642 was inaccurate as she stated LPN #642 could not have measured the wound if the dressing dated 06/14/26 was not removed. She revealed the assessment was struck out due to data entry error per ADON/LPN #741 on 06/17/26 at 1:01 P.M after this surveyor had brought it to the facility's attention. She verified the last wound assessment documented for Resident #61's right hand was on 06/09/26 and wound assessments were to be completed weekly. Review of the email dated 06/17/26 at 12:47 P.M. from RN #629 to DON revealed Resident #61 was supposed to put his light on after eating 2:30 A.M. but never turned his light back on for it. Then an incident occurred on the unit, so I never got a chance to go back or correct the documentation. Observation on 06/17/26 at 3:55 P.M. of wound care completed by ADON/LPN #739 and ADON/LPN #741 after Resident #61 returned from dialysis revealed ADON/LPN #741 removed the dressing to his right hand dated 06/14/26 at 3:00 P.M. that had been completed by RN #682. As ADON/LPN #741 removed the dressing she stated, it is sticking and Resident #61 stated, if the dressing change goes more than a day it dries all out. ADON/LPN #741 described the wound to his right hand as gangrene from fingers to wrist and the upper wrist wound area had a small amount of brown crusting with serosanguinous drainage (a thin watery, pink-tinged fluid) at the base of where the gangrene stopped with pink tissue surrounding and no signs of infection. They completed the treatment as ordered. ADON/LPN #741 verified there was not a dressing to his left upper extremity, and she completed the dressing as ordered. Review of facility policy labeled, Wound Care, dated 2001 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote wound healing. The nurse was to verify there was a physician order for the procedure. The following information should be documented including type of wound care, date and time the wound care was given, any change in condition, assessment data including wound bed color, size, drainage, and if the resident refused the treatment the reason why. This deficiency represents non-compliance investigated under Master Complaint Number 3040367 and Complaint Number 3035796.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to ensure medical records contained accurate documentation. This affected one resident (Resident #61) out of five residents reviewed for accuracy of documentation. The facility census was 102.Findings include:Review of medical record for Resident #61 revealed an admission date of 05/04/26 and his diagnoses included diabetes, chronic renal failure requiring dialysis, orthopedic aftercare following surgical amputation, gangrene (blood flow to specific area was compromised leading to tissue death and potential for amputation), absence of left hand, absence of right leg above the knee, and absence of left leg above the knee.Review of June 2026 physician orders and June 2026 Treatment Administration Record (TAR) revealed Resident #61 had an order dated 05/11/26 to cleanse right hand areas with warm soapy water and dial soap, pat dry, make sure area was fully dry before applying dressing, apply light application of bacitracin ointment over the wound only, do not put bacitracin (topical antibiotic ointment) over the surrounding tissue, apply xeroform (a sterile, non-adhering wound dressing made of fine-mesh gauze impregnated with petroleum jelly and an antibacterial agent) to open areas, cover with four-by-four gauze and wrap with kerlix (gauze wrap) every shift (6:00 A.M. and 6:00 P.M.) and as needed. The treatment was not signed as completed in the TAR on 06/06/26 at 6:00 A.M. On 06/14/26 at 6:00 P.M, Registered Nurse (RN) #629 signed off the above treatment as completed; however, on 06/15/26 at 6:00 A.M, Licensed Practical Nurse (LPN) #603 made a treatment administration note which specified the resident's treatment was not completed, following shift informed with no reason provided as to why it was not completed. On 06/15/26 at 6:00 P.M., RN #615 signed off the above treatment as completed as ordered; on 06/16/26 at 6:00 A.M., LPN #616 signed off the above treatment as completed as ordered; and on 06/16/26 at 6:00 P.M., RN #629 signed off the above treatment as completed as ordered. Resident #61 had a physician order dated 05/19/26 to cleanse surgical incision to left upper extremity with normal saline, apply abdominal (ABD) pad, and wrap with gauze wrap daily and as needed. The TAR revealed on 06/15/26 at 6:00 A.M., LPN #603 made a treatment administration note which specified the Resident #61's treatment was not completed, following shift informed with no reason provided as to why it was not completed. There was no further documentation the treatment was completed on 06/15/26. On 06/16/26, LPN #616 signed off the above treatment as completed as ordered. There was also a physician order dated 05/07/26 for the nurse to evaluate his right-hand wound including assessing for drainage, signs of infection, necrotic tissue, odor, issues with surrounding tissue and pain every shift. The TAR revealed on 06/14/26 at 6:00 P.M., RN #629 signed off she had assessed his wound. On 06/15/26 at 6:00 A.M., LPN #603 made a treatment administration note which specified the resident's wound was not assessed stating, not completed, following shift informed with no reason provided as to why it was not completed. On 06/15/26 at 6:00 P.M., RN #615 signed off she had assessed his wound; on 06/16/26 at 6:00 A.M., LPN #616 signed off she had assessed his wound; and on 06/16/26 at 6:00 P.M., RN #629 signed off she had assessed his wound. Review of Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was cognitively intact. He was dependent on staff for all his activities of daily living (ADLs) and had a surgical wound.Review of the After Visit Summary dated 06/08/26 completed by Orthopedic Physician Assistant (OPA) #742 revealed Resident #61 had a follow-up consult, and she recommended doing daily skin checks and a dressing change to the left upper extremity. She also recommended twice daily dressing changes to the right upper extremity of cleansing the areas to the right hand with warm soapy water and dial soap, pat dry, make sure area fully dry before applying dressing, apply light application of bacitracin ointment over the wound only, do not put bacitracin over the surrounding tissue, apply xeroform (a sterile, non-adhering wound dressing made of fine-mesh gauze impregnated with petroleum jelly and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an antibacterial agent) to open areas, cover with four-by-four gauze and wrap with kerlix (gauze wrap). She also recommended monitoring for signs of infection including redness, warmth, drainage, foul smell, fevers or chills.Review of care plan last revised 06/10/26 revealed Resident #61 had an old bilateral above the knee amputation and new hand amputation (left). Interventions included checking and documenting on the wound daily for signs of infection, monitoring for excessive wound drainage, and changing the dressing as ordered.Review of the Skin Only Evaluation dated 06/16/26 completed by LPN #642 revealed Resident #61 had an area to his right wrist measuring 3.0 centimeters (cm) length, 1.6 cm width, and 0.1 cm depth. There were no other descriptions and the note specified to continue treatment as ordered. This assessment was struck out due to data entry error by Assistant Director of Nursing (ADON)/LPN #741 on 06/17/26 at 1:01 P.M.Observation and interview on 06/17/26 at 11:21 A.M. with Resident #61 revealed he was lying in bed, and he did not have a wound dressing to his left upper extremity. His fingers on his right hand were gangrenous, and a gauze wrap was covering his hand and wrist area. The dressing to his right hand was dated 06/14/26 at 3:00 P.M. with RN #682's initials. Resident #61 revealed his dressing to his right hand was to be completed twice a day as ordered per OPA #742 and that the last time they had changed it was on 06/14/26 at 3:00 P.M. He complained the nurses frequently did not complete his wound dressing changes and was concerned he was going to lose his hand because they were not following the physician order. He also stated they do not do the treatment to his left upper extremity as ordered as the last time it was done was also on 06/14/26 at 3:00 P.M. by RN #682. The dressing to his left upper extremity had since fallen off on 06/15/26.Interview on 06/17/26 at 11:44 A.M. with ADON/ LPN #741 verified the dressing to Resident #61's right hand was dated 06/14/26 at 3:00 P.M. and the dressing was to be completed twice a day. She verified the TAR revealed on 06/14/26 at 6:00 P.M., RN #629 had signed off the above treatment as completed; on 06/15/26 at 6:00 A.M., LPN #603 made a treatment administration note which specified the treatment was not completed, following shift informed; on 06/15/26 at 6:00 P.M., RN #615 signed off the above treatment as completed; on 06/16/26 at 6:00 A.M., LPN #616 signed off the above treatment as completed; and on 06/16/26 at 6:00 P.M., RN #629 signed off the above treatment as completed. She verified the documentation was inaccurate as his treatment had not been done since 06/14/26 at 3:00 P.M. per the dated dressing. Interview on 06/17/26 at 12:05 P.M. and 06/18/26 at 9:10 A.M. with Director of Nursing (DON) verified Resident #61's dressing to his right hand was last changed on 06/14/26 at 3:00 P.M. She verified the dressing was to be changed twice a day as ordered by OPA #742 and verified the nurses had documented the dressing was changed and the documentation was not accurate. She also verified there was a physician order to evaluate his wound to his left hand every shift (6:00 A.M. and 6:00 P.M.) and that the nurse had signed off as this was completed 06/14/26 at 6:00 P.M., 06/15/26 at 6:00 P.M., and 06/16/26 at 6:00 A.M. and 6:00 P.M. She verified the wound was not assessed as the dressing was never removed since 06/14/26 at 3:00 P.M and the documentation was not accurate. She verified the Skin Only Evaluation dated 06/16/26 completed by LPN #642 was inaccurate as LPN #642 could not have measured/assessed his right hand if the dressing was in place dated 06/14/26. She revealed the assessment was struck out due to data entry error per ADON/LPN #741 on 06/17/26 at 1:01 P.M when this surveyor brought to the facility's attention. Review of the email dated 06/17/26 at 12:47 P.M. from RN #629 to DON revealed Resident #61 was supposed to put his light on after eating 2:30 A.M. but never turned his light back on for it. Then an incident occurred on the unit, so I never got a chance to go back or correct the documentation.Observation on 06/17/26 at 3:55 P.M. of wound care completed by ADON/LPN #739 and ADON/LPN #741 after Resident #61 returned from dialysis revealed ADON/LPN #741 removed the dressing to his right hand dated 06/14/26 at 3:00 P.M. that had been completed by RN #682. Review of facility policy labeled, Charting and Documentation, dated 2001 revealed the documentation in the medical record would be objective, complete and accurate. This deficiency represents non-compliance investigated under Master Complaint Number 3040367 and Complaint Number 3035796.