STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365250	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Care and Rehabilitation	1900 East Main Street Lancaster, OH 43130

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure wound care treatment and assessments were appropriately implemented and completed. This affected one resident (#76) out of three residents reviewed for wound care. The facility census was 93.Record review for Resident #76 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Parkinsonism, dementia, and dysphagia.Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/01/25, revealed the resident was assessed to have impaired cognition.Review of the nurses' progress note, dated 04/07/25, revealed right thigh healed. Treatment orders discontinued.Review of the care plan, revised 06/25/25, revealed the resident was at risk for impaired skin integrity. Interventions included blister to right thigh (05/10/25).Review of the facility eINTERACT SBAR (Situation, Background, Appearance, Review) form, dated 05/09/25, revealed the resident was assessed to have a new blister present to the right thigh with green and yellow drainage present. The physician was notified and new orders for laboratory testing and Levaquin (an antibiotic medication) were given and implemented.Review of the physicians orders for Resident #76 revealed no wound care treatment for the blister on the residents right thigh were implemented from 05/09/25 through 08/17/25.Review of the facility assessments from 05/09/25 through 08/17/25 revealed no assessment indicating the presence or description of the blister to Resident #76's right thigh was present.Observation on 08/18/25 at 2:14 P.M. revealed Resident #76 was lying in bed asleep with his pants removed for comfort. A small white bandage was in place to the residents right thigh which contained the initials of Licensed Practical Nurse (LPN) Manager #164. Interview with LPN Manager #164 at the time of the observation confirmed a small scab was observed on the residents right thigh and treatment orders were obtained from the physician and implemented. LPN #164 confirmed no new skin areas were present to her knowledge prior to 08/18/25.Observation on 08/19/25 at 9:15 A.M. with LPN Manager #164 revealed wound care was provided to the area on Resident #76's right thigh. A small open area approximately the size of a dime was present. The skin surrounding the open area was pink and no signs of infection were noted.Interview with LPN #262 on 08/19/25 at 10:47 A.M. confirmed Resident #76 had a small burn present to his right thigh which had healed around 04/07/25. LPN #262 confirmed she was working and providing care for Resident #76 on 05/09/25 and noticed a new blister to the residents right thigh which had green and yellow drainage present. LPN #262 confirmed she had notified the physician and obtained new orders for Levaquin to be administered and laboratory testing to be conducted. LPN #262 confirmed she notified Registered Nurse (RN) #166 of the presence of the wound and was told to clean the wound, apply Medi-honey (an ointment to treat wounds), apply a bandage and check on the wound as often as possible. LPN #262 confirmed wound care treatment orders were never implemented and wound assessments had never been conducted or documented. LPN #262 confirmed herself and RN #166 had been changing the bandage to the residents thigh when working in the facility and the area had continued to be present from 05/09/25 through 08/19/25.Interview with Certified Nursing Assistant (CNA) #268 on 08/18/25 at 1:02 P.M. confirmed Resident #76 had a wound present to his right thigh which had been there for a while. CNA #268 confirmed LPN #262 changed the bandage to the wound and had been doing so for a while.Interview with Assistant Director of Nursing (ADON) #263 on 08/19/25 at 11:57 A.M. confirmed the facility should implement and follow wound care treatment orders obtained by the physician and wounds were to be assessed and documented weekly. ADON #263 confirmed no wound care treatment orders had been implemented for the blister to Resident #76's right thigh from 05/09/25 through 08/17/25 and also confirmed no assessment of the wound had been completed or documented from 05/09/25 through 08/17/25. Review of the facility policy titled Wound Care, revised 10/2010, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Verify there is a physician's order for this procedure. The following information should be recorded in the resident's medical record: The type of wound care given, the date and time the wound care was given, the name and title of the individual performing the wound care, any change in the residents' condition, all assessment data obtained when inspecting the wound, and how the resident tolerated the procedure.This deficiency represents non-compliance identified during the investigation of Complaint 1386024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interview, the facility failed to ensure residents remained free from burns. This affected one resident (#76) out of three residents reviewed for accidents. The facility census was 93.Record review for Resident #76 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Parkinsonism, dementia, and dysphagia.Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/01/25, revealed the resident was assessed to have impaired cognition.Review of the nurses progress note, dated 02/20/25, revealed Resident #76 had spilled coffee on himself during lunch. The resident would not allow staff to remove his pants to assess the area where coffee had spilled.Review of the nurse progress note, dated 02/20/25, revealed Resident #76 had been brought back from the dining area after he had spilled coffee on himself. The nurse completed a head-to-toe assessment, and a blister was present to the right outer leg with some redness noted. The immediate intervention was use of restrictive flow cup for hot liquids. The physician and responsible party were notified of the area and new intervention. Review of the Interdisciplinary Team (IDT) Note, dated 02/22/25, revealed the IDT met to review related to occurrence on 02/20/25. All aspects of the plan of care were in place at the time of occurrence. All safety interventions were in place and functional at time of occurrence. Resident was brought back from the dining area and had spilled coffee on himself. His liquids were in a lidded cup with handles at the time of the occurrence. The nurse completed a head-to-toe assessment with a blister noted to the right outer leg with some redness present. The immediate intervention was use of restrictive flow cups with hot liquids. Provide and responsible party notified. IDT in agreement with intervention and orders and updated POC (Plan of Care).Review of the facility Skin and Wound Evaluation, dated 02/24/25, revealed there was a second degree burn to the right thigh assessed. The wound measured 10.5 centimeters (cm) long by 6.6 cm wide. No pain was assessed to be present related to the wound, and no signs or symptoms of infection were noted. Interview with Assistant Director of Nursing (ADON) #263 on 08/19/25 at 11:57 A.M. confirmed Resident #76 sustained a burn from spilling hot coffee on himself on 02/20/25. ADON #263 confirmed the resident had been assessed by Occupational Therapy (OT) prior to the incident and was recommended to have a two handled cup with spouted lid used while consuming liquids to prevent spillage and burns, and the resident was using the cup as ordered at the time of the incident. ADON #263 confirmed treatment orders for the burn were obtained and implemented and the burn was resolved without infection or complications on 04/07/25. ADON #263 confirmed a restrictive flow cup was implemented for use with all hot liquids after the incident on 02/20/25 to further decrease the risk for spills or burns for Resident #76. This deficiency represents noncompliance investigated under Complaint Number 1386024.