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	11/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff interview, and facility policy review, the facility failed to report an alleged violation to the state department of health in a timely manner. This affected one (Resident #43) of three incidents reviewed. The census was 93.Findings Include: Observation on 11/17/25 at approximately 11:55 A.M. revealed Resident #43 lying in bed with a white towel lying over her right shoulder/upper arm area. She was observed with a slight grimace as if in pain. Resident #43 was admitted to the facility on [DATE]. Her diagnoses were Parkinson's disease, abnormal posture, mild cognitive impairment, muscle weakness, dementia, unspecified protein calorie malnutrition, herpes-viral vesicular dermatitis, dysphagia, mixed hyperlipidemia, major depressive disorder, obesity, anxiety disorder, hydrocephalus, psychosis, hypertension, obstructive sleep apnea, Type II Diabetes, vitamin D deficiency, chronic ischemic heart disease, mood disorder, weakness, drug induced subacute dyskinesia, and constipation. Review of her minimum data set (MDS) assessment, dated 11/05/25, revealed she was cognitively intact. Review of Resident #43's nurse's notes, dated 11/16/25, revealed an entry at 8:10 P.M. that stated resident was being transferred from her bed to her wheelchair when she felt weakness in her legs and was unable to hold on to the sit to stand machine. Staff placed her back into her bed. They noted on the progress note there were no injuries/issues. Review of Resident #43's nurse's note, dated 11/16/25, revealed an entry at 8:28 P.M., another recount of the incident with the sit to stand machine and stated Resident #43 was not in pain at this time. Review of Resident #43's nurse's note, dated 11/16/25, revealed an entry at 10:15 P.M., resident reported to the nurse her arm was hurting. Moderate swelling noted in the right shoulder/arm region. She stated there was pain in that area and it hurt when she moved it. Physician was contacted and a stat X-ray was ordered. Review of Resident #43 nurse's note, dated 11/17/25, revealed an entry at 10:24 A.M. that was an interdisciplinary note which documented a review of the incident with the sit to stand machine. The note documented there was no injury or complaint of pain from the resident. There was no mention of an X-ray being ordered or completed. Review of Resident #43's nurse's note, dated 11/17/25, revealed an entry at 12:13 P.M. that an X-ray was completed for Resident #43 and an order to send her to the emergency room for further evaluation. Review of Resident #43's X-ray result, dated 11/17/25, revealed the results arrived at the facility at approximately 11:45 A.M. and documented the resident had a fractured neck of the humerus, which is why she was ordered to be sent to the emergency room for further evaluation. Review of Resident #43's Witness Fall report, dated 11/16/25, revealed the narrative for the incident was a replication of the progress notes listed above from 11/16/25. The notifications were made by facility staff on 11/16/25 at 8:09 P. M., but at the top of the witness fall form, it stated the incident happened on 11/16/25 at 11:40 A.M. Review of facility investigative documents for Resident #43's incident, dated 11/16/25, revealed there was an interview statement from Resident #43, who stated she felt the fracture of her arm came from the incident with the sit to stand machine on 11/16/25. There were no interview statements from the two aides who provided the physical assistance with the sit to stand machine to determine how the incident occurred, or if the nurse's notes were an accurate description of what happened. Review of facility reported incidents (FRI), dated 11/01/25 to 11/17/25, revealed no FRI reported regarding this incident. The facility was made aware of the fracture on 11/17/25 at 11:45 A.M., and as of 1:45 P.M., there was no FRI filed as required. Interview with Director of Nursing on 11/17/25 at 2:55 P.M. and 3:35 P.M. confirmed they were made aware of Resident #43's fracture on 11/17/25 at 11:45 A.M. She confirmed they immediately reached out to the physician, and they got an order to send the resident to the emergency room for further monitoring and observation. The DON confirmed they did not file an FRI, further stating they knew the injury occurred the day before when Resident #43 had an incident they considered a fall, using the sit to stand machine. When asked how she knew this, the DON confirmed there was a nurse's note about the incident and stated she spoke with Resident #43 who stated she felt the injury occurred during the incident with the sit to stand machine. The DON confirmed she had not spoken with the two aides who were assisting Resident #43 with the transfer to determine what happened, and if they had used the sit to stand machine appropriately. She also confirmed the nurse's notes in the electronic medical records were not written by the two aides who were in the room at the time of the incident. The DON also confirmed the incident report and nurse's notes were not written until nine hours after the incident occurred; confirming the incident occurred on 11/16/25 at 11:40 A.M., and it was not documented until 8:10 P.M. She confirmed they were planning to interview the