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	04/24/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, and interview the facility failed to ensure a wound treatment was implemented timely. This affected one (Resident #93) of three residents reviewed for wounds. The facility census was 91. Findings include:Review of the closed medical record revealed former Resident #93 was admitted on [DATE] with diagnoses that included Parkinson's disease with dyskinesia, dementia, congestive heart failure, dysphagia, and adult failure to thrive. Resident #93 expired at the facility on [DATE]. A plan of care dated [DATE] revealed Resident #93 was at risk for pressure ulcers (development). Interventions included to encourage and assist the resident with turning and repositioning upon rounds and as needed. If an ulcer developed, the wound nurse, Director of Nursing (DON), family, and medical doctor would be notified. Incontinence care as indicated to be provided, and weekly nursing assessments completed to observe for skin breakdown.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #93 had severe cognitive impairment. Resident #93 was dependent on staff for toileting, hygiene, bathing, rolling side to side, and sitting to laying. Resident #93 was always incontinent with bowel and bladder. The MDS revealed the resident had no skin concerns. A skin tear/laceration form dated [DATE] at 10:35 A.M. revealed Resident #93 had a skin tear that measured 1.49 centimeters (cm) long and 1.11 cm wide to the right hip. It was believed to be caused by the resident scratching himself. The wound was cleansed with wound cleanser, and a dressing was applied per physician order. Resident #93's nails were to be trimmed to avoid skin issues in the future. Review of the treatment administration record (TAR) for February 2026 revealed no treatments were in place or completed for the area to Resident #93's right hip/trochanter. The skin issues evaluation dated [DATE] at 3:37 P.M. revealed the abrasion to Resident #93's right trochanter/hip wound had deteriorated. The wound measured 2.94 cm long and 1.76 cm wide. The dressing was intact and there was not saturation.Review of the TAR revealed on [DATE] a treatment to Resident #93's right hip was started. The wound was to be cleansed with Dakins (broad-spectrum, antiseptic, antimicrobial cleanser) wound cleanser (DWC), patted dry, with Mesalt (sodium chloride dressing used to stimulate the cleansing of moist necrosis in draining and infected wounds) applied, and covered with a dry clean dressing every day until healed. The treatment was completed from [DATE] through [DATE].The skin issues evaluation dated [DATE] at 1:15 P.M. revealed the abrasion to Resident #93's right trochanter wound had deteriorated. The wound measured 3.53 cm long and 3.53 cm wide. Signs of infection included erythema/edema (redness may be intense bright red to dark red or purple), and the peri wound temperature was warm.Review of the Medication Administration Record (MAR) and TAR revealed on [DATE] a treatment to Resident #93's right hip was changed. The new treatment revealed the resident's right hip was to be cleansed with DWC, patted dry, a nickel thick amount of Santyl (breaks down dead tissue in skin ulcers) applied to slightly moistened (with normal saline) gauze, and applied to the wound bed. The wound was to be covered with a dry, clean dressing daily until healed.An interview on [DATE] at 12:58 P.M. Registered Nurse (RN) #147 verified she was the facility wound nurse. RN #147 stated she felt the wound was due to an abrasion or skin tear from Resident #93 scratching himself. RN #147 stated there was just a layer of skin gone so it was classified as a skin tear/abrasion and not a pressure wound. RN #147 verified an outside wound (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician, and hospice did not assess the wound at any time. RN #147 verified the wound was discovered on [DATE] and treatments were not put in place until [DATE]. The following deficiency is based on incidental findings discovered during the course of this complaint investigation.