

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Buckeye Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37100</p> <p>THIS DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, review of a Self-Reported Incident, resident interview, staff interview, and facility policy review, the facility failed to ensure a resident was free from physical restraints. This affected one (Resident #56) out of one resident reviewed for abuse. The census was 93.</p> <p>Findings include:</p> <p>Review of Resident #56's medical record revealed Resident #56 was admitted to the facility on [DATE]. Resident #56's diagnoses included but were not limited to epilepsy, difficulty in walking, altered mental status, schizophrenia, cognitive communication deficit, dementia, insomnia, mood disorder, major depressive disorder, and anxiety disorder.</p> <p>Review of Resident #56's Minimum Data Set assessment, dated 04/09/24, revealed Resident #56 was cognitively intact.</p> <p>Review of the facility Self-Reported Incident (SRI) number 246866, dated 04/28/24, revealed Resident #56 alleged Licensed Practical Nurse (LPN) #500 sat on her in the smoking area. Resident #56 allegedly became combative and was hitting and kicking at LPN #500. The incident occurred after Resident #56 went outside after smoking hours and LPN #500 was trying to get Resident #56 back inside. The SRI revealed Resident #56 had a bruise/discolored area to her shoulder from hitting the bench outside. Interview statements were written by the Administrator, based on interviews he completed with each witness. The witnesses did not sign the statements.</p> <p>Interview with Resident #56 on 05/13/24 at 3:01 P.M. and on 05/16/24 at 10:22 A.M. revealed she was very frustrated and upset that she was not allowed to smoke when she wanted. She revealed she was grabbed and restrained by LPN #500, who was telling her she needed to go back in the facility when it was considered after hours for smoking.</p> <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrator on 05/15/24 at 2:16 P.M. revealed they thoroughly investigated the incident between Resident #56 and LPN #500. He stated he did not find any evidence of abuse, but confirmed he found evidence that LPN #500 sat on Resident #56 while they were outside. He stated due to this incident, they have adjusted their smoking policy to give the nurse discretion to allow residents to smoke between 10:00 P.M. and 6:30 A.M. if the nurse feels that not allowing a resident to smoke would be detrimental. He confirmed they have not asked LPN #500 to return to work at the facility.</p> <p>Interview with LPN #315 on 05/16/24 at approximately 2:00 P.M., revealed she was in the doorway to the courtyard area during the entire incident between LPN #500 and Resident #56. LPN #500 had asked her to go with him to the courtyard as a witness to telling Resident #56 she could not be smoking after 10:00 P.M. They both went to the courtyard and LPN #500 went to the area where Resident #56 was located and she stayed in the doorway. She heard Resident #56 and LPN #500 arguing about having to go inside and not being allowed to smoke. There was no physical altercations until LPN #500 grabbed Resident #56's wrist. After LPN #500 grabbed her wrist, Resident #56 attempted to swat his hand to let her go and LPN #500 continued to hold her wrist. After a couple minutes of continuing to try to get Resident #56 inside, LPN #500 pulled Resident #56's wrist close to her body and it appeared LPN #500 was holding her wrist to restrain her. At that point, LPN #500 moved in front of Resident #56, pushed his backside against Resident #56's body, and appeared to sit on her while they were both on the bench outside. While this occurred, two other aides went outside to see if they could help the situation. LPN #500 got off Resident #56 after a couple minutes, and one of the aides was able to calm her down to walk her back inside the building. When asked if she felt the physical contact by LPN #500 was necessary due to Resident #56 hitting LPN #500, LPN #315 stated it was not because Resident #56 did not physically engage with LPN #500 until he grabbed her wrist. LPN #315 confirmed LPN #500 initiated the physical contact and was restraining Resident #56.</p> <p>Review of facility Abuse Prevention Policy, dated 10/02/19, revealed the facility will prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation of all residents. This includes, but not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The definition of abuse was defined as the willful infliction, unreasonable confinement, intimidation, or corporate punishment with resulting physical harm, pain, or mental anguish.</p> <p>Review of the facility's corrective action plan revealed the following actions were implemented and the deficiency corrected as of 05/03/24:</p> <p>On 04/28/24, a head to toe assessment was completed on Resident #56 and Resident #56 was found to have a slight bruise noted to her right shoulder.</p> <p>On 04/28/24, LPN #500 was suspended pending the outcome of the investigation.</p> <p>On 04/28/24, the Administrator/designee interviewed all current residents who were able to effectively communicate, and re-evaluated all current residents who were not able to effectively communicate to determine if there were any injuries of unknown origin or suspicion of abuse. No concerns were noted.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/28/24, the Administrator/designee educated all current staff on the facility abuse policy, which included the use of physical restraints. Also, all current staff were educated on proper customer service and de-escalation techniques.</p> <p>On 04/30/24, the Administrator/designee completed a weekly audit of five residents which included interviews with the residents. No concerns were reported.</p> <p>On 05/02/24, the Administrator/designee reviewed the smoking policy and added a provision for situations where a resident may be agitated or trying to decompress while smoking outside of designated times. This update grants the nurse the authority to deviate from the standard policy to prioritize the safety of both the resident and the staff.</p> <p>On 05/02/24, the Administrator/designee re-educated current staff and current resident smokers on the updated smoking policy.</p> <p>On 05/03/24, the Administrator/designee terminated LPN #500's employment due to issues with poor customer service.</p> <p>On 05/06/24, the Administrator/designee completed a weekly audit of four residents which included interviews with the residents regarding any care concerns. No concerns were reported.</p> <p>On 05/09/24, the Administrator/designee completed a weekly audit of four residents which included interviews with the residents regarding any care concerns. No concerns were reported.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47987</p> <p>Based on observation, staff interview and facility policy review, the facility failed to ensure multi use vials of tuberculin purified protein derivative (PPD) were dated when they were opened. This had the potential to affect all 93 residents in the facility. The census was 93.</p> <p>Findings include:</p> <p>Observation on 05/14/24 at 10:49 A.M. of the medication room refrigerator located on Maple Street and Main Street revealed an opened box with a used vial of tuberculin PPD five unit/0.1 milliliter(ml) one ml/vial with no date as to when it was opened.</p> <p>Interview on 05/14/24 at 10:50 A.M. with Licensed Practical Nurse (LPN) #299 verified there was no date as to when the tuberculin PPD vial was opened and stated, I know it was just opened yesterday as this is our last vial in the facility as there was a new admission and we do that for all new admission residents.</p> <p>Review of the facility policy titled Administering Medications, dated April 2019, revealed the policy stated when opening a multi-dose container, the date opened is recorded on the container.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>41266</p> <p>Based on review of the menu, review of the dietary spreadsheet, observations, staff interview, and review of facility policy, the facility failed to ensure the menu was followed. This affected 23 residents (Residents #1, #3, #6, #10, #13, #18, #22, #32, #36, #40, #41, #43, #45, #50, #59, #63, #69, #77, #81, #85, #153, #247, and #299) who were ordered a dysphagia advanced, mechanical soft, or pureed diet. The facility census was 93.</p> <p>Findings include:</p> <p>Review of the menu for the lunch meal on 05/15/24 revealed the meal consisted of a cheeseburger on a bun, lettuce and tomato, French fries, creamy coleslaw, and a cookie.</p> <p>Review of the dietary spreadsheet for the lunch meal on 05/15/24 revealed residents who received a dysphagia advanced diet should have received a sandwich with ground cheeseburger and a cup of shredded lettuce. Residents who received a mechanical soft diet should have received a number 10 scoop of ground pureed cheeseburger. Residents who received a pureed diet should have received a number 10 scoop of pureed cheeseburger.</p> <p>Interview on 05/15/24 at 10:35 A.M. with Cook #211 revealed there were no changes to the menu made for the lunch meal on 05/15/24.</p> <p>Observation on 05/15/24 at 10:35 A.M. of Cook #211 preparing pureed food items revealed the cook used a number 10 scoop to place eight scoops of ground meat with a red sauce into the blender. There were no buns or bread added to the blender.</p> <p>Interview on 05/15/24 at 10:37 A.M. with Cook #211 revealed he used a homemade recipe to make sloppy joes and was not making cheeseburgers for the residents. Cook #211 stated the sauce keeps it more moist for the residents.</p> <p>Observation on 05/15/24 at 10:39 A.M., revealed Cook #211 stopped the blender, emptied the pureed sloppy joes into a metal serving container, covered it with plastic wrap, and placed it in the steamer to keep it warm until it was time to be served.</p> <p>Observations on 05/15/24 from 11:35 A.M. to 12:15 P.M. of the lunch meal tray line with Cook #211 revealed the cook served ground sloppy joes on a bun to residents on a dysphagia advanced diet or mechanical soft diet. Cook #211 used gloved hands to scoop a handful of shredded lettuce on to the plates and did not use a portion controlled utensil to ensure the residents received one cup of shredded lettuce as indicated on the dietary spreadsheet. Cook #211 served pureed sloppy joes (without any bun) to residents who received a pureed diet.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/15/24 at 2:24 P.M. with the Dietary Manager (DM) #200, Cook #211, and the Administrator confirmed Cook #211 did not follow the dietary spreadsheet for the lunch meal. Cook #211 confirmed he served sloppy joes instead of cheeseburgers. Cook #211 confirmed he did not add any buns to the pureed sloppy joes and did not have pureed bread on the tray line. Cook #211 stated, usually I puree it all together but I just forgot today. Cook #211 confirmed he used gloved hands to scoop and plate shredded lettuce instead of using a portion control utensil to ensure the appropriate amount was plated for the residents.</p> <p>Review of the facility policy titled Food Preparation and Service, revised 11/2022, revealed the policy stated, the facility will have spreadsheets for all meals coordinated with the weekly menus. These will indicate portion sizes for each menu item as well as any necessary modifications or substitutions to specific menu items for modified textures and therapeutic diets, making it clear to the staff just how to handle special situations without confusion. The Registered Dietician will review all spreadsheets and menus.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266</b></p> <p>Based on observation, staff interview, and facility policy review, the facility failed to ensure food was not expired and was stored appropriately. Additionally, the facility failed to ensure staff practiced proper hand hygiene when handling food. This had the potential to affect all 93 residents who resided in the facility. The facility identified all 93 residents received meals from the kitchen. The census was 93.</p> <p>Findings include:</p> <p>1. During an initial tour of the kitchen on [DATE] from 11:40 A.M. to 11:50 A.M. with Dietary Manager (DM) #200, the following food items were observed in the refrigerator: one large half used container of salsa with a use by date of [DATE], one large unopened bag of brown, soggy shredded lettuce with a use by date of [DATE], one bag of fresh grapes which were opened, exposed to the air and undated, one unopened bag of pre-sliced potatoes with a use by date of [DATE], and one small partially used bottle of Red Hot hot sauce which was undated.</p> <p>Interview on [DATE] at 11:45 A.M. with DM #200 confirmed the above findings and DM #200 discarded the items from the refrigerator.</p> <p>Observation of the freezer on [DATE] at 11:47 A.M. revealed there was one large bag of premade peanut butter cookie dough cookies, opened, exposed to the air, and undated.</p> <p>Interview on [DATE] at 11:50 A.M. with DM #200 confirmed there was one large bag of premade peanut butter cookie dough cookies, opened, exposed to the air, and undated in the freezer. DM #200 discarded it from the freezer.</p> <p>Review of the facility policy titled Food Receiving and Storage, revised ,d+[DATE], revealed the policy stated foods shall be received and stored in a manner that complies with safe food handling practices.</p> <p>2. Observations on [DATE] at 11:25 A.M. of Cook #211 checking food temperatures revealed Cook #211 donned one clean glove on his right hand without completing any hand hygiene prior to putting the clean glove on. Cook #211 used his gloved hand to handle French fries in order to obtain a temperature. Cook #211 removed the glove after obtaining the temperature and discarded it in the trashcan. Cook #211 did not complete any hand hygiene after removing the glove and continued checking food temperatures. At 11:28 A. M., Cook #211 donned one clean glove on his right hand without completing any hand hygiene prior to putting the glove on. Cook #211 used his gloved hand to handle slices of cheese in order to obtain a temperature. After obtaining a temperature, Cook #211 removed the glove and discarded it in the trashcan. Cook #211 did not complete any hand hygiene after removing the glove. Cook #211 then started tray line.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on [DATE] at 11:35 A.M., revealed Cook #211 placed two large plastic bags of hamburger buns on a cart with his bare hands then donned clean gloves to both hands. Cook #211 did not complete any hand hygiene prior to putting on the clean gloves. Cook #211 used his gloved hands to scoop a handful of shredded lettuce, a tomato slice, and two onion slices onto a plate to serve to a resident. With the same gloves on, Cook #211 then grabbed a hamburger bun from the plastic bag and placed it on the plate. The cook used tongs to place a hamburger patty onto the bun and then used the same gloved hands to place a slice of cheese on top of the hamburger patty and then placed the top of the bun on top of the cheeseburger. Cook #211 did not complete any hand hygiene or change his gloves and continued to use the same process for several more plates. At 11:46 A.M., Cook #211 placed a #10 scoop of pureed sloppy joe meat, mashed potatoes with gravy, and pureed carrots into three separate bowls and placed plastic lids on each bowl with the same gloves on. At 11:55 A.M., Cook #211 removed his gloves, discarded them in the trashcan, and washed his hands at the sink. Cook #211 donned two more clean gloves. At 12:00 P.M., Cook #211 used his gloved hands to move the cart that had the hamburger buns on it. The cook then ripped open one of the plastic bags of buns. Cook #211 did not change gloves or complete any hand hygiene and continued using his gloved hands to handle plates, shredded lettuce, tomato slices, onion slices, slices of cheese, and hamburger buns with the same gloves on. At 12:02 P.M., another male kitchen staff handed Cook #211 two large bags of frozen French fries from the freezer. Cook #211 used his gloved hands to open both bags of fries and dump them into the fryer. Cook #211 did not remove his gloves or complete any hand hygiene and again continued to handle plates, shredded lettuce, tomato slices, onion slices, slices of cheese, and hamburger buns while wearing the same gloves.</p> <p>Interview on [DATE] at 2:24 P.M. with the Administrator, Dietary Manager (DM) #200, and Cook #211 confirmed Cook #211 should have washed his hands before donning clean gloves and/or after removing gloves. Cook #211 confirmed the above observations of not following appropriate hand hygiene procedures during the lunch meal service.</p> <p>Review of the facility policy titled Food Preparation and Service, revised ,d+[DATE], revealed the policy stated, cross-contamination can occur when harmful substances are transferred to food by hands (including gloved hands). Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use.</p>		