

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility risk management investigations, interview, and policy review, the facility failed to ensure allegations/ incidents of potential resident to resident physical abuse were reported to the State survey agency as required. This affected one (Resident #1) of two residents reviewed for abuse. Findings include: Review of Resident #1's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified psychosis, dementia, generalized anxiety disorder, major depressive disorder, Parkinson's disease, and a history of a fractured upper end of the right humerus (11/21/25). Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had minimal difficulty with her hearing and clear speech. She was usually able to make herself understood and was usually able to understand others. She was cognitively intact and not known to have displayed any behaviors during the seven day assessment period. She had a functional limitation in her range of motion of one side of her upper and lower extremities. A wheelchair was used as a mobility device. Review of Resident #1's nurses' progress notes revealed a nurse's note dated 12/15/25 at 2:44 P.M. that indicated the resident reported to an aide that another resident had hit her. The nurse was immediately notified and entered the resident's room. The resident was alert and oriented times three (person, place, and time) and was able to provide credible information. The resident reported another resident wheeled by her and smacked her arm. The nurse's note was struck out for a correction on 12/21/25 at 5:53 P.M. An amended note dated 12/21/25 at 5:53 P.M. added social services provided evaluation as an immediate intervention to prevent further occurrences. Further review of Resident #1's nurses' progress notes revealed a nurse's note dated 12/24/25 at 4:12 P.M. indicated the nurse was alerted by staff the resident was hit by another resident on the left arm three times with a carrying bag. The residents were immediately separated and the resident's safety was ensured. A head to toe assessment was completed on the resident with no apparent injuries at that time. Resident #1's cognition was intact and she was able to provide credible information regarding the incident. The resident would be closely monitored for any further inappropriate interactions and would use the sitting room at the end of her hall away from the other resident. On 01/05/26 at 9:59 A.M., an interview with Resident #1 revealed another resident (Resident #90) hit her on the left arm with a bag. She alleged the incident had happened about a month ago and she was hit three times with the bag. She alleged she continued to have issues with that resident, who still resided in the facility. She reported other incidents in the past with the same resident. Review of the Ohio Department of Health (ODH) Certification and Licensing (CAL's) application (a system used by the facility to report allegations of abuse/ neglect/ misappropriation to the State survey agency) revealed there was not any self-reporting incidents (SRI's) that reported any allegations of potential physical abuse of Resident #1 by Resident #90. Findings were verified by the Director of Nursing (DON) on 01/08/26 at 2:39 P.M. On 01/08/26 at 2:40 P.M., an interview with the facility's DON revealed the facility did not submit a SRI for either incident occurring between Resident #1 and #90 that occurred on 12/15/25 and again on 12/24/25. She acknowledged both incidents involved Resident #1 being hit by Resident #90 and they should have (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been reported to the State survey agency as possible physical abuse. She reported the facility had completed an investigation through their risk management team, but did not feel it was something that had to be reported to the State survey agency. She was asked, why she did not feel the physical altercations between Resident #1 and #90 did not need to be reported to ODH, and replied the facility did not feel Resident #90 had any malicious intent to harm Resident #1. She did not feel Resident #90 was willful in her attempt to harm Resident #1, due to Resident #90's known developmental disability. She further acknowledged the definition of willful was a deliberate act and there did not need to be the intent to inflict harm. One resident hitting another resident was a deliberate act and should be reported even if the alleged abuser had a developmental disability. Review of the facility's policy on Abuse/ Neglect revised April 2021 revealed residents had the right to be free from abuse. That included but was not limited to physical abuse. They were to protect residents from abuse by anyone, including other residents. They were to investigate and report any allegations within the timeframes required by federal requirements.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure resident-centered care plans were individualized and comprehensively addressed all areas of the residents' care this affected two residents (Residents #17 and #65) of 28 residents reviewed for care plans. The facility census was 88. Findings Include: 1. Review of the medical record for Resident #17 revealed an admission date of 04/05/2024 with diagnoses including Ogilvie syndrome (intestinal pseudo-obstruction), schizoaffective disorder, major depressive disorder, suicidal ideations, insomnia, hypertensive heart disease, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment completed on 12/22/25 revealed Brief Interview for Mental Status (BIMS) score of 15 indicating he was cognitively intact. Additionally, he was dependent on staff for toileting, personal hygiene/grooming, and positioning in his bed; required moderate assistance with dressing his upper and lower body; and required supervisory assistance with eating, oral care, showering, and mobility in his manual wheelchair. Review of the nurse's progress notes revealed Resident #17 began exhibiting signs of depression and suicidal ideations beginning on 09/01/25. He was evaluated and treated at the hospital and returned to the facility on the same day. He received counseling services in the community on 09/02/25, and his physician adjusted his psychoactive medications on 09/04/25 with instructions to provide him with daily notifications on how the resident was tolerating the new dosage adjustments. On 09/05/25, Resident #17 returned to the hospital after displaying symptoms associated with serotonin syndrome and continued suicidal ideations. He was admitted to the hospital on [DATE] and remained hospitalized until 09/18/25. Review of Resident #17's active care plan revealed his care plan was revised on 09/25/25 to reflect he was at risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual well-being related to mood interview triggered and diagnosis of schizoaffective disorders, depression, suicidal ideations, insomnia, and anxiety. The goal was to assess clinical issues that may contribute to his mood pattern; encourage the expression of his feelings and concerns, participation in activities of interest; maintaining a calm, understandable approach; observe for signs and symptoms of depression and emotional distress and notify the physician as needed; referring to psychiatry/psychology as ordered; and for social services to visit and evaluate as needed. The care plan did not comprehensively address specific behaviors, triggers, or interventions to properly manage his depression and/or suicidal ideations. Interview on 01/06/26 at 12:29 P.M. with Resident #17 revealed he has an average of weekly appointments with his community psychiatric nurse practitioner and counselor, the facility-contracted psychiatrist, and his primary medical doctor who worked together to treat his psychiatric symptoms. He stated his current medication regimen addressed his symptoms. Interview on 01/08/25 at 9:14 A.M. with Social Services Director (SSD) #650 stated she is responsible for assessing the psychosocial needs of residents in the facility and updating care plans to address specific needs. SSD #650 confirmed Resident #17's care plan did not specifically address suicidal ideation. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 01/05/26 at 11:31 A.M. revealed Resident #65 had very poor dentition. He was missing teeth and the teeth present had visible decay. Review of Resident #65's medical record revealed an admission date of 04/27/25 with diagnoses including bipolar disorder, moderate protein-calorie malnutrition, major depressive disorder, anxiety disorder, orthostatic hypotension, and other seizures. Review of Resident #65's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had moderately impaired cognition. Review of Resident #65's plan of care dated 05/06/25 revealed the resident was at risk for oral issues. He needed assistance with oral care and had his own teeth. Interventions included dental consultation as indicated, oral exam and intervention as indicated, and notifying the physician of symptoms of dental infection or complications. Interview on 01/08/26 at 10:59 A.M. with the Director of Nursing (DON) verified Resident #65 had poor dentition and his dental condition was not in his care plan, with goals to manage his individualized needs. Review of the facility policy titled, Comprehensive Person-Centered Care Plans, (revised March 2022) confirmed the comprehensive, person-centered care plan should include measurable objectives to meet the resident's physical, psychosocial, and functional needs. The policy states the care plan was to be revised as information about the resident and the resident's conditions change. The policy also states the interdisciplinary team reviews and updates the care plan when the resident has been readmitted to the facility from a hospital stay.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews the facility failed to ensure residents were provided with timely hygiene care to removing facial hair. This affected two residents (Residents #36 and #55) of the four residents reviewed for activities of daily living. The facility census was 88. Findings include: 1. Review of Resident #36 ' s medical record revealed an admission date of 03/07/25 with diagnosis to include but not limited too Parkinson's disease, pain in right shoulder, difficulty in walking, unsteadiness on feet, chronic obstructive pulmonary disease, hyperlipidemia, bipolar, obesity, osteoarthritis, gastro-esophageal reflux disease, major depressive disorder, anxiety, heart failure, seizures, hypertensive heart disease, and anemia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #36 required required touching assistance for personal grooming to include shaving. Review of the care plan focus initiated 03/12/25 and revised on 10/03/25 revealed Resident #36 had an actual risk for Activities of Daily Living (ADL) decline and required staff assistance related to impaired mobility related to right shoulder pain with interventions which to included resident required staff assistance with hygiene. Observation of Resident #36 who was sitting in a wheelchair in a common area on 01/05/26 at 1:44 P.M. revealed the resident had multiple white hairs on her chin which were long and noticeable. Interview with Resident #36 on 01/05/26 at 1:44 P.M. revealed the resident stated I can not find tweezers to get rid of the chin whiskers, the girls usually shaved them, but they did not today. Interview on 01/05/26 at 1:51 P.M. with License Practical Nurse (LPN) #480 confirmed and verified Resident #36 had multiple long white hairs on her chin and Resident #36 had asked for them to be removed but they remained. 2. Review of Resident #55 ' s medical record revealed an admission date of 04/14/21 with diagnosis to include but not limited to atrial fibrillation, hypertension, osteoarthritis, anxiety disorder, hypothyroidism, major depressive disorder, ischemic heart disease, anemia, hypo-osmolality and hyponatremia. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated a moderate cognitive impairment. Resident #55 required moderate assistance for showering and personal hygiene which included shaving. Review of the shower sheet dated 01/03/26 for Resident #55 revealed a blank space where it should be documented if Resident #55 had a shower or not. Review of the care plan for Resident #55 revealed a focus which stated Resident #55 had an ADL self-care performance deficit related to impaired mobility with interventions revised on 02/10/23 to include Resident #55 required staff assistance for showering and personal hygiene to include shaving. Observation on 01/05/26 at 1:22 P.M. of Resident #55 revealed she had multiple black hairs on her upper and lower lips which had the appearance of a mustache. Interview on 01/05/26 at 1:22 P.M. with Resident #55 confirmed the black hair on her upper and lower lips bothered her because it does not look good. Interview on 01/05/26 at 1:27 P.M. with LPN #480 revealed the female residents have their facial hair shaved on shower days and when it is noticeable. Additionally, LPN #480 stated the expectation is for the Certified Nursing Assistants (CNAs) to shave the female residents who have facial hair even if it is not their shower day. Interview on 01/05/26 at 1:33 P.M. with LPN #480 who confirmed and verified Resident #55 had multiple black hairs on her upper and lower lips and Resident #55 asked for it to be shaved but it remained. Review of the facility policy Activities of Daily Living (ADL), Supporting revision dated 03/2018 stated that residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Furthermore, the facility policy Activities of Daily Living (ADL), Supporting revision dated 03/2018 stated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with: hygiene (bathing, dressing, grooming, and oral care).This deficiency represents non-compliance investigated under Complaint Number OH002706168.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, policy review, and staff interview, the facility failed to ensure a wound was properly identified as a pressure ulcer. This affected one (Resident #4) of three residents reviewed for pressure ulcers. The facility census was 88. Findings Include: Review of the medical record for Resident #4 revealed an admission date of 06/06/25 with diagnoses including inflammatory disorders of scrotum, gangrene Fournier, dementia, and cerebral infarction. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was at risk for pressure ulcers and the resident had one or more pressure ulcers. Review of the care plan dated 06/09/25 and revised on 01/05/26 revealed Resident #4 was at risk for pressure ulcer/skin breakdown related to impaired mobility, medication, fragile skin, diagnosis, Diabetes Mellitus (DM), hyperlipidemia, cerebral vascular accident (CVA), obstructive sleep apnea, osteoarthritis, acute kidney injury, rhabdomyolysis, right hip pain, depression, insomnia, chronic obstructive pulmonary disease (COPD), dysphagia, dementia, urinary retention, hyponatremia, anemia, mitral endocarditis, malnutrition, history of Fournier gangrene, and resident can be non-compliant with safety, mobility, activities of daily living (ADL's), care, showers, and preventative skin measures. Subsequent review of the care plan revealed Resident #4 had a resolved stage II pressure ulcer (partial-thickness skin loss, appearing as a shallow, open sore, blister, or crater, with a pink/red wound bed, but no visible fat or deeper tissue) to sacrum, a stage II pressure ulcer to left gluteus, surgical wound to scrotum, an intact blister to left heel, and a blister to rear left knee. A skin and wound evaluation dated 10/08/25 revealed a wound to left heel identified as a blister. The wound measured 4.6 centimeters (cm) long, 3.5 cm wide and depth not applicable. A progress note dated 12/03/25 with wound nurse practitioner revealed an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) to left heel and wound was covered with 100% eschar (a dark patch of dead skin that forms over a wound acting as a hard scab). Further review of wound evaluations revealed an assessment dated [DATE] identifying the left heel wound as a blister and no unstageable pressure ulcers identified. Observation on 01/07/26 at 2:47 P.M. of wound care on Resident #4 with RN #690 revealed an unstageable pressure ulcer to the left heel, covered with eschar. Interview on 01/07/26 at 2:50 P.M. with RN #690 revealed Resident #4's left heel wound started as an intact fluid filled blister and is now an unstageable pressure ulcer. RN #690 confirmed an intact fluid filled blister can be identified as a stage II pressure ulcer according to the facility's pressure ulcer policy citing the National Pressure Injury Advisory Panel Classification System and the wound was not documented properly. Review of the facility's policy titled Pressure Injuries Overview, dated March 2020 revealed a pressure ulcer/ injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medial or other device. Stage 2 pressure injury: The wound is viable, pink or red, moist and may also present as an intact or ruptured serum-intact blister.		

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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 review, observation, staff interview, and policy review, the facility failed to ensure residents did not smoke in an area that also had residents with portable oxygen on. This affected one (Resident #23) of one residents reviewed for smoking. The facility also failed to ensure fall prevention interventions were implemented as per the plan of care for a resident with the history of falls. This affected one (Resident #35) of four residents reviewed for falls. Findings include:1. Review of Resident #23's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia, schizo-affective disorder, multiple rib fractures on the left and right side, fracture of the sacrum, chronic obstructive pulmonary disease (COPD), difficulty walking, and muscle weakness. Review of Resident #23's smoking observation assessment dated [DATE] revealed the resident was a smoker and was known to smoke cigarettes. She had cognitive impairment and was able to light her own cigarette. The assessment determined she could smoke but required supervision. Review of Resident #23's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate difficulty with hearing and clear speech. She was usually able to make herself understood and was usually able to understand others. Her cognition was moderately impaired. Review of Resident #23's active care plans revealed she had a care plan in place for the potential for injury related to smoking, desires to smoke, and may smoke with supervision per the facility's smoking policy. The care plan originated on 10/10/25. The goal was for the resident's safety to be maintained every shift through the review date. The interventions included educating the resident on the facility's smoking policy and oxygen safety requirements, precautions, and, if on oxygen, remove oxygen before taking the resident out to smoke. Those on oxygen were to maintain a safe distance from designated smoking areas. She was to be supervised at all times by staff while in the courtyard. Review of Resident #23's physician's orders revealed the resident had an order for continuous oxygen at three liters per minute (LPM) per nasal cannula. The order for the oxygen use originated on 12/04/25. As of 12/10/25, she had an order to wean oxygen as the resident never wore oxygen at home. Her orders also included the need for her to be supervised in the courtyard at all times. On 01/05/2026 at 1:36 P.M., an observation noted Resident #23 to be sitting by the door to the facility's courtyard/ designated smoking area. She was noted to be wearing oxygen per nasal cannula that was connected to an e-tank on the back of her wheelchair. Housekeeper #425 was observed to approach Resident #23 and informed her she needed to take her oxygen off before going outside to smoke. Housekeeper #425 was observed assisting the resident with removing the nasal cannula from the resident's nares before placing the oxygen tubing across the back of the wheelchair the resident was sitting in. Seven residents went out to smoke in the enclosed courtyard/ designated smoking area to include Resident #23. Housekeeper #425 had a tackle box that contained the residents' smoking materials and she passed them out to the residents one at a time. Resident #23 was noted to have her oxygen tank still on the back of her wheelchair and it remained on at three LPM. Air was able to be felt coming out of the end of the oxygen tubing from the nasal cannula by placing your hand over the end of the tubing that was draped over the back of the wheelchair. Housekeeper #425 approached Resident #23 to light the cigarette the resident was given at 1:42 P.M. The surveyor had to intervene and stop the housekeeper from lighting the resident's cigarette while the oxygen tank remained on the back of her wheelchair and turned on. LPN #145 was also in the designated smoking area, as she was completing a smoking assessment on another resident (Resident #73) at that time. She had previously been noted to remove Resident #73's oxygen from his nares placing his e-tank in his room before allowing him to go outside to smoke. LPN #145 was in close proximity of Resident #23, but did not recognize Resident #23 still had her oxygen tank on the back of her wheelchair and her oxygen tank turned with the oxygen tubing draped over the back of the wheelchair. On 01/05/26 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:49 P.M., an interview with LPN #145 revealed the facility's normal process was not to allow residents with oxygen tanks to be out in the designated smoking area when residents were smoking. She commented oxygen should never be on the back of a chair outside, ever. On 01/05/26 at 2:00 P.M., an interview with Housekeeper #425 revealed she was normally the staff member that took residents outside to smoke. It was usually just her unless there was an aide out there with her. The aide was busy working the hall that day and was not able to accompany her for that smoking time. She denied Resident #23 had been out to smoke the past couple of days. She had not known her to have a portable oxygen tank on the back of her wheelchair when out to smoke in the past. She stated it would be her responsibility to ensure residents did not go out to smoke with oxygen on. An aide brought Resident #23 down by the door to the designated smoking area and she would have assumed the aide had already taken Resident #23's oxygen off or at least turned the oxygen off at the tank. She acknowledged she should have ensured the oxygen tank was left inside the building and not allowed to be on the back of her wheelchair when the resident went out to smoke. She was not familiar with oxygen tanks and did not know how to turn them off. She confirmed they were not supposed to allow an oxygen tank to go out with a resident when going out to the smoking area with the intent to smoke. She stated it was her bad that she did not catch it, and she was aware of the safety risk of a potential burn injury with smoking near/ or around oxygen. Review of the facility's Smoking Policy revised 05/05/25 revealed it was the policy of the facility to accommodate their smoking and non-smoking residents. The goal was for the residents to be able to smoke safely per policy after passing a smoking assessment. The purpose of the policy was to ensure the residents of the facility, who smoke, to have a comfortable and safe environment in which to smoke. The use of oxygen while smoking was strictly prohibited. 2. Review of Resident #35's medical record revealed he was admitted to the facility on [DATE] with the diagnoses of dementia, anxiety disorder, major depressive disorder, insomnia, and hypotension (low blood pressure). Review of Resident #35's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had adequate vision, adequate hearing, and clear speech. He was usually able to make himself understood and was usually able to understand others. His cognition was moderately impaired. He was not known to have displayed any behaviors and was not known to reject care. He had a functional limitation in his range of motion of his bilateral lower extremities. He required substantial/ maximum assist with bed mobility and was dependent on staff for transfers. Review of Resident #35's care plans revealed he had a care plan in place for being at risk for falls related to impaired safety awareness, medication use, impaired mobility, and diagnoses that increased his risk for falls. The goal was for the resident to be compliant with fall interventions through next review. The interventions included the need for his bed to be in low position. That intervention was added on 04/05/25. Review of Resident #35's physician's orders revealed an order for him to have the use of a perimeter mattress. His orders also included the need for his bed to be in low position. That order originated on 04/20/25. Review of Resident #35's progress notes revealed a nurse's note dated 04/20/25 at 3:24 A.M. that indicated the resident rolled out of bed while sleeping. The new intervention added to prevent additional falls was for a low bed to be put in place. On 01/06/2026 11:22 A.M. an observation of Resident #35 noted him to be in bed in a supine position. He had a perimeter mattress on his bed, but his bed was not in it's lowest position. On 01/06/26 at 2:21 P.M., a follow up observation of Resident #35 noted him to remain in bed with his bed raised and not in it's lowest position. His bed was about 24 inches from the bottom of the bedframe to the floor. On 01/06/26 at 2:25 P.M., an interview with LPN #160 revealed she did not consider Resident #35 to be a fall risk as he does not move. She confirmed the resident has fallen in the past, but it was not enough to consider him a fall risk at that time. He was always in bed and denied that he got up. She was asked what fall prevention interventions were in place for the resident. She stated she did not know without checking his orders. She denied any problems with Resident #35 and had not known him to use his own bed controls to raise or lower his bed. She was asked to go to his room to verify the bed not being in it's lowest position. She verified the bed was up (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Buckeye Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 East Main Street Lancaster, OH 43130	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about 18 inches higher than it should have been. She lowered the bed from being about 24 inches from bed frame to floor to only being six inches off the floor. She confirmed his active care plans and physician's orders included the need for the bed to be in the lowest position for safety/ fall risk.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy the facility failed to timely complete an ordered urinalysis laboratory test and appropriately address a urinary tract infection (UTI) for Resident #52. This affected one resident (#52) of three residents reviewed for UTI's. The facility census was 88. Findings include: Review of Resident #52's medical record revealed an admission date of 05/28/21 with diagnoses including Parkinson's disease, Type II Diabetes Mellitus, progress multiple sclerosis, unspecified protein-calorie malnutrition, dysphagia, legal blindness, and dementia. Review of Resident #52's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #52's physician note dated 11/10/25 revealed the resident complained of lower abdominal pain. The physician wanted an urinalysis (UA) with culture and sensitivity and recommended encouraging fluids while the results were pending. Review of Resident #52's physician order dated 11/11/25 revealed an order for urinary analysis with culture and sensitivity. Review of Resident #52's progress note dated 11/12/25 revealed the UA was not collected. Review of Resident #52's physician order dated 11/18/25 revealed an order for urinary analysis with culture and sensitivity. Review of Resident #52's physician order dated 11/18/25 revealed an order for Ciprofloxacin Hcl (an antibiotic) 250 milligrams one tablet to be given by mouth every 12 hours for three days for infection. Review of Resident #52's progress note dated 11/19/25 revealed the UA was not collected. Review of Resident #52's progress note dated 11/20/25 revealed the resident showed up in the laboratory's system for a UA, however, she had been on an antibiotic for two days. The physician was asked if he still wanted a UA and on 11/21/25 he reported the order could be discontinued. Review of Resident #52's medical record from 11/10/25 to 11/20/25 revealed no further documentation related to her UTI. Interview on 01/08/26 at 8:42 A.M. with the Director of Nursing verified Resident #52's UA was not completed timely as ordered. She was unsure why it was not completed, and verified there was no documentation on 11/18/25 to indicate why an antibiotic was ordered, or what symptoms she still had. She additionally verified an antibiotic was ordered without a UA, she reported due to the continued symptoms the physician did not wait for the results. Review of the policy 'Antibiotic Stewardship', revised December 2016 revealed when a culture and sensitivity is ordered, the lab results and current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be continued or modified. This deficiency represents non-compliance investigated under Complaint Number 2706168.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to adequately monitor the nutritional status of a resident with the history of a significant weight loss. This affected one (Resident #37) of one residents reviewed for nutrition. The census was 88. Findings include: Review of Resident #37's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included progressive multiple sclerosis, mild dementia, schizo-affective disorder, major depressive disorder, adult onset Diabetes Mellitus, dysphagia (difficulty swallowing), Vitamin B and D deficiencies, anemia, hyperlipidemia (high cholesterol), hypokalemia (low potassium), moderate protein calorie malnutrition, and constipation. Review of Resident #37's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was usually able to understand others and was usually able to make herself understood. Her cognition was moderately impaired and mood indicators included a poor appetite. Her height was 65 inches and her weight was 128 pounds. She was known to have a significant weight loss without being on a physician prescribed weight loss program. Review of Resident #37's active care plans revealed she had a care plan in place for being at nutritional risk secondary to her diagnoses, medication use, and a history of significant weight loss. Her goal was to consume at least 75% of most meals to maintain weight. Interventions included the need to monitor/record/report to the physician any signs or symptoms of malnutrition. They were to offer substitute meals if the resident consumed less than 50%, provide and serve diet as ordered, and administer supplements (House Supplement 237 milliliters (ml) twice daily. The registered dietitian (RD) was to evaluate and make diet change recommendations as needed (PRN). Review of Resident #37's physician's orders revealed she was to be on a regular diet. She was to receive a house nutritional supplement 237 ml twice a day for oral consumption. The house supplement was initiated on 10/24/25. Review of Resident #37's weight history revealed the resident weighed 145 pounds on 06/24/25. Her weight reduced to 129.6 pounds on 12/09/25 reflecting a significant weight loss of 10.62% in six months. Her last weight obtained on 01/02/26 had her weight as 126 pounds. She was noted to have a significant weight loss at 1, 3 and 6 months, since 06/24/25, reflecting a loss of 6.9% in one month, 8.5% at 3 months and 10.62% at six months. Review of Resident #37's meal intakes for the past 30 days (12/09/25- 01/06/26) revealed the resident did not have any of her three meals consumed recorded on 12/11/25, 01/02/26, or 01/04/26. There was only one of the three meals recorded on 12/31/25, and only two of the three meals recorded on 12/16/25 and 01/06/26. It was not clear what percentage of the meals the resident consumed on those days or if she had received a meal at all. Review of Resident #37's medication administration record (MAR) for December 2025 and January 2026 revealed the nurses were documenting the resident's acceptance of her house nutritional supplement when offered twice daily. The nurses were inconsistent in the manner in which they were recording the resident's supplement acceptance. Some nurses were documenting the percent of the supplement consumed while others were putting a Y on the MAR to indicate that the supplement was accepted but not the percentage consumed. There were five times between 12/01/25 and 01/06/26 that the nurse just entered a Y, without documenting the percentage consumed. On 01/07/26 at 12:35 P.M., an interview with the facility's Director of Nursing (DON) revealed it was an expectation that the nurses documented the percentage of the house nutritional supplement that the resident consumed when given twice a day as ordered. She acknowledged the nurses were not always specifying the percentage of the supplement the resident consumed as there were five times in the past two months they just added a Y. She confirmed, by the nurses entering a Y, that just indicated the house supplement had been given. It was not clear how much of the house supplement had been taken when it was just marked as a Y. She further confirmed the resident's meal intakes were not consistently being recorded under the task tab of the EMR. She acknowledged there were three days in the past 30 days where the resident's meal intake was not recorded for any of the (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three meals served that day. She further acknowledged there was only one of the three meals recorded on 12/31/25, and only two of the three meals recorded on 12/16/25 and 01/06/26. She acknowledged, by not recording the resident's supplement acceptance and not recording meal intakes for all three meals received daily, they were not showing evidence of the resident's nutritional status being adequately monitored, after the resident was known to have had a significant weight loss. It would also make it hard to determine if the house nutritional supplement was an effective nutritional intervention, if it was not known how much the resident was consuming. Review of the facility's policy on Food and Nutrition Services revised October 2017 revealed each resident was to be provided with a nourishing, palatable, well-balanced diet that met their daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Meals and/ or supplements would be provided within 45 minutes of either resident request or scheduled meal time. Nursing personnel would evaluate and document food and fluid intake of residents with, or at risk for, significant nutritional problems.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent duplicate pain medication orders and when administering as needed medications they failed to attempt nonpharmacological interventions and describe the pain for Resident #2 and #5. This affected two residents (#2 and #5) of one of five residents reviewed for unnecessary medications and one of one resident reviewed for pain. The facility census was 88. Findings include: 1. Review of Resident #2's medical record revealed an admission date of 04/02/24 with diagnoses including paranoid personality disorder, Post-traumatic stress disorder (PTSD), mood disorder, Parkinson's disease, epilepsy, personality disorder, bipolar disorder, dementia, unspecified psychosis, mild cognitive impairment, depressive disorder, Type II Diabetes Mellitus, and chronic kidney disease. Review of Resident #2's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. The resident received insulin, antipsychotics, antianxiety medication, antidepressants, diuretics, opioids, anticonvulsants, and hypoglycemics. Review of Resident #2's plan of care dated 10/28/25 revealed the resident was at risk for pain or discomfort related to diagnoses, her pain was expected to fluctuate. Interventions included administering medications and treatments as ordered, assessing pain every shift, assessing for non-verbal indicators of pain, and dimming light for photosensitivity. Review of Resident #2's physician order dated 06/30/25 revealed an order for Dilaudid (opioid) four milligrams (mg) one tablet by mouth every four hours as needed for pain. Review of Resident #2's physician order dated 12/21/25 revealed an order for Dilaudid Oral Tablet four mg one tablet by mouth every four hours as needed for pain one through ten. Review of Resident #2's Medication Administration Record for December 2025 and 01/01/26 through 01/05/26 revealed Dilaudid was given on 12/02/25 once, on 12/04/25 twice, on 12/05/25 once, on 12/06/25 once, on 12/07/25 twice, on 12/08/25 once, on 12/11/25 twice, on 12/12/25 twice, on 12/14/25 once, on 12/15/25 once, on 12/16/25 once, on 12/17/25 once, on 12/20/25 twice, on 12/27/25 once, on 12/29/25 twice, on 12/31/25 once, on 01/01/25 once, and on 01/04/25 once. Both orders of Dilaudid were used. Review of Resident #2's progress notes dated 12/01/25 through 01/05/26 revealed on 12 occasions she was given as needed pain medication without nonpharmacological methods being attempted and without a description of her pain. On two occasions she was given as needed pain medication without a description of her pain. Interview on 01/08/26 at 10:14 A.M. with the Director of Nursing (DON) verified nursing is supposed to attempt and document nonpharmacological interventions prior to administering as needed pain medication, she additionally verified the nursing staff was not documenting descriptions of her pain. The DON verified there were two orders of Dilaudid in use for Resident #2 and there should not have been. 2. Review of Resident #5's medical record revealed an admission date of 05/21/25 with diagnoses including cerebral palsy, cerebral infarction, dementia, osteoarthritis, neoplasm of unspecified behavior of brain, major depressive disorder, abnormal posture, and spinal stenosis. Review of Resident #5's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #5's plan of care dated 11/07/25 revealed the resident exhibited or was at risk for alteration in comfort related to generalized discomfort and diagnoses. Interventions included evaluating pain characteristics, utilizing pain scale, completing pain assessment per protocol, medications as ordered, nonmedication interventions including relaxation, repositioning, and redirection. Review of Resident #5's physician order dated 11/11/25 revealed an order for Oxycodone (opioid)-Acetaminophen (analgesic) five-325 milligrams (mg) one tablet by mouth every six hours as needed for pain. Review of Resident #5's Medication Administration Record (MAR) for December 2025 and 01/01/26 through 01/05/26 revealed he received Oxycodone-Acetaminophen on 12/01/25 three times, on 12/02/25 twice, on 12/3/25 once, on 12/04/25 twice, on 12/05/25 once, on 12/06/25 once, on 12/07/25 twice, on 12/08/25 once, on 12/09/25 twice, on 12/10/25 twice, on 12/11/25 twice, on 12/12/25 twice, on 12/13/25 twice, on 12/14/25 twice, on 12/15/25 twice, on 12/16/25 twice, on (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/17/25 twice, on 12/20/25 twice, on 12/21/25 three times, on 12/22/25 twice, on 12/23/25 twice, on 12/24/25 three times, on 12/25/25 twice, on 12/26/25 three times, on 12/27/25 twice, on 12/28/25 twice, on 12/29/25 twice, on 12/30/25 once, on 12/31/25 once, on 01/01/26 twice, on 01/02/26 once, on 01/03/26 once, on 01/04/26 three times, and on 01/05/26 twice. Review of Resident #5's progress notes revealed on 35 occasions he was given as needed pain medication without nonpharmacological methods being attempted and without a description of his pain. Interview on 01/08/26 at 10:14 A.M. with the Director of Nursing (DON) verified nursing is supposed to attempt and document nonpharmacological interventions prior to administering as needed pain medication. She additionally verified the nursing staff was not documenting descriptions of his pain.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, staff interview, manufacturer guide review, and facility policy review, the facility failed to ensure medication error rate was less than five percent. There were two observed medication errors of 28 opportunities observed, resulting in a 7.14 percent medication error rate. This affected one Resident (#103) out of three residents reviewed for medication administration and had the potential to affect 15 residents who received insulin at the facility. Facility census was 88. Findings Include: Review of the medical record for Resident #103 revealed an admission date of 12/31/25 with diagnoses including alcoholic hepatitis without ascites, Type II Diabetes Mellitus, and heart failure. Review of physicians orders dated 12/31/25 revealed an order for Insulin Glargine (long acting insulin) subcutaneous solution Pen-Injector 100 unit/ML (milliliter), inject 20 units subcutaneous (sq) two times a day for diabetes mellitus and Insulin Aspart (fast acting insulin) subcutaneous solution Pen-Injector 100 unit/ML, inject per sliding scale before meals and at bedtime for diabetes mellitus. Observation on 01/07/26 at 8:13 A.M. with Registered Nurse (RN) #660 of medication administration revealed RN #660 prepared Resident #103's Insulin Glargine and Insulin Aspart and did not prime the insulin pens prior to administration. Interview on 01/07/26 at 8:17 A.M. with RN #660 verified the insulin pens were not primed prior to dialing up the dose administered to the resident. RN #660 stated he thought the insulin pens only needed primed after opening the insulin for the first time. Review of Insulin Aspart step-by-step manufactures guide verified a safety test (airshot) must be performed before each injection by dialing a test dose of two units, hold the pen with the needle pointing up lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. Review of Insulin Glargine step-by-step manufactures guide verified a safety test must be performed before each injection by dialing a test dose of two units, hold the pen with the needle pointing up lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. Review of facility policy titled Administering Medications dated April 2019 revealed medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow enhanced barrier precautions (EBP) as guided by the Centers for Disease Control and Prevention (CDC) for Resident #4 and failed to ensure hand hygiene was performed during catheter care for Resident #9. This affected two of five residents reviewed for infection control. The facility census was 88. Findings include: 1. Review of the medical record for resident #4 revealed an admission date of 06/06/25 with diagnoses including inflammatory disorders of scrotum, gangrene fournier, dementia, and cerebral infarction. Review of physician's orders dated 10/04/25 revealed an order for enhanced barrier precautions during high contact resident care two times a day for foley catheter. Observation on 01/08/26 at 1:28 P.M. revealed a bed bath being performed by CNA #665 with Resident #4. Interview on 01/08/26 at 1:31 P.M. with CNA #665 verified the signage was posted on the door for enhanced barrier precautions due to resident having a catheter and she was not following enhanced barrier precautions, as required by CDC guidance. Review of facility policy titled Enhanced Barrier Precautions dated December 2024, revealed examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, prolonged high-contact with items in the residents room, with residents equipment, or with residents clothing or skin, device care or use and wound care. 2. Review of Resident #9's medical record revealed an initial admission date of 10/30/25 and a re-entry admission dated of 11/11/25 with diagnosis to include but not limited to acute and chronic respiratory failure, calculus of kidney, disorders of the kidney and ureter, Type II Diabetes Mellitus, obstructive and reflux uropathy, acute kidney failure, encephalopathy, dementia, abdominal pain, sepsis, urinary tract infection, hydronephrosis, elevation of levels of liver transaminase, retention of urine, atrial fibrillation, anxiety disorder, and overactive bladder. Review of an order dated 11/11/25 stated enhanced barrier precautions during high contact resident care every day and night shift for preventative. Review of an order dated 11/11/25 stated catheter care every shift. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #9 was dependent (staff does all the effort) on staff for toileting hygiene and showering. Review of the care plan last revised on 12/18/25 for Resident #9 revealed a focus for an indwelling foley catheter related to obstructive uropathy with inventions to include provide catheter care and empty catheter every shift and as needed, perform catheter care and as needed following protocols to maintain cleanliness and reduce infection risk, and provide catheter care and hygiene practices with cleaning daily and as needed and as need after bowel movements per policy to reduce infection risk. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, the care plan for Resident #9 revealed a focus for enhanced barrier precautions during high-contact resident activities due to the presence of an indwelling device not known to be infected or colonized with any multi-drug resistant organism (MDRO) with interventions to include utilize protective personal equipment (PPE) (gown, gloves, and face-shield as indicated) during high-contact resident care activities (dressing, bathing/showering, transferring, hygiene, line changes, brief changes, toileting assistance, device care, wound care). Observation on 01/06/26 at 3:40 P.M. of catheter care for Resident #9 performed by Certified Nurse Assistant (CNA) # 500 revealed CNA #500 did not perform hand hygiene before donning gown and gloves prior to starting catheter care. The CNA was observed to leave the resident room twice during the catheter care and when she returned to the room she did not perform hand hygiene prior to donning gloves. The CNA was then observed to moved Resident #9's trash can from one side of the bed to the other side of the bed with her gloved hand and then with the same hand was observed to reached inside her pocket and get a trash bag. CNA #500 was observed to place the trash bag on the floor and without doffing gloves, performing hand hygiene, and donning gloves CNA #500 was observed to perform catheter care on Resident #9. Interview on 01/06/26 at 4:15 P.M. at the end of the observation of catheter care with CNA #500 it was confirmed and verified she did not wash her hands before donning gown and gloves before catheter care, or when she returned to the room after she left on two different occasions. Additionally, CNA #500 confirmed and verified she had no open trash bags to place dirty linen or trash in and had gloves on to take the trash bags from her pocket and then placed the trash bags on the floor, and did not change her gloves before touching and performing catheter care on Resident #9. Review of the facility policy Catheter Care, Urinary dated 08/2022 stated for routine perineal hygiene wash and dry hands thoroughly, put on gloves, provide privacy. Review of the facility policy Handwashing/Hand Hygiene dated 10/2023 stated hand hygiene is indicated immediately before touching a resident, before performing an aseptic (free from contamination caused by harmful bacteria, viruses, or other microorganisms) task (for example, placing an indwelling catheter or handling and invasive device medical device), after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching a residents environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after gown removal. Review of the facility policy Enhanced Barrier Precautions dated 12/2024 stated enhanced barrier precautions (EBPs) are utilized to prevent the spread of MDROs to residents. EBPs apply when a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices (including urinary catheters), and does not have secretions or excretions that are unable to be covered or contained. EBPs employ targeted gown/glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high contact resident care activities requiring the use of gowns and gloves for EBPs include device care or use (urinary catheter). Furthermore, the facility policy Enhanced Barrier Precautions dated 12/2024 stated staff are trained prior to caring for residents on EBPs.		

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 01/08/2026
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure Resident #52 ' s wheelchair was maintained in a clean and sanitary manner. This affected one resident (#52) of three residents reviewed for environment. The facility census was 88. Findings include: Review of Resident #52's medical record revealed an admission date of 05/28/21 with diagnoses including Parkinson's disease, Type II Diabetes Mellitus, progress multiple sclerosis, mild cognitive impairment, unspecified protein-calorie malnutrition, legal blindness, dementia, and major depressive disorder. Review of Resident #52's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Observation on 01/06/26 at 2:50 P.M. and on 01/08/26 at 10:05 A.M. revealed Resident #52's wheelchair had a large build up of dirt, food, stains, and splatters along the sides and edges. Interview on 01/08/26 at 10:05 A.M. with the Director of Nursing (DON) verified Resident #52's wheelchair needed cleaned, she reported it was on the schedule for night shift. This deficiency represents non-compliance investigated under Complaint Number 2706168.		