STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365344	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe Rehabilitation and Care Center	957 Becks Knob Road 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 - 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** 41271 Based on closed medical record review, hospital record review, interview, and facility policy review, the facility failed to ensure Resident #139, who was admitted to the facility on [DATE] was provided antibiotics timely and as ordered at the time of hospital discharge and failed to ensure laboratory testing associated with the antibiotic use was completed as required to properly treat the resident's osteomyelitis and to prevent complications. Actual harm occurred on 10/01/24 when Resident #139 was transferred to the hospital for treatment of Vancomycin toxicity and acute kidney injury after the facility failed to monitor the antibiotic through laboratory testing. This affected one resident (#139) of eight residents reviewed for laboratory monitoring/testing. The facility census was 137. Findings include: Review of the closed medical record for Resident #139 revealed an admitted [DATE] with diagnoses including Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer of the sacral region, osteomyelitis of vertebra sacral and sacrococcygeal region, and the use of antibiotics. Record review revealed the resident was discharged to the hospital on 10/01/24. Review of Resident #139's Clinical Discharge Instructions from the hospital dated 09/18/24 revealed under section titled Discharge Diagnosis and Plan revealed the resident was receiving intravenously (IV) Cefepime (antibiotic) and Vancomycin (antibiotic) which would be continued for 6 to 8 weeks. Weekly labs. Labs ordered included C-Reactive Protein, CBC with Diff, Erythrocyte Sedimentation Rate, Renal Function Panel, and Vancomycin Trough level. However, review of the resident's physician admission orders, dated 09/18/24 revealed no orders were written for the resident to continue/receive the IV Cefepime or IV Vancomycin at the facility. In addition, there were no admission orders written for weekly labs as noted in the resident's clinical discharge instructions from the hospital dated 09/18/24. Record review revealed no evidence facility staff obtained clarification of these orders at the time of admission. (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 - Actual harm Residents Affected - Few	Review of a progress note dated 09/18/24 at 9:55 P.M. created by Licensed Practical Nurse (LPN) #250 revealed Resident #139 was admitted to the facility at 8:00 P.M. via ambulance on a stretcher. The resident was a full code (advance directives), had no known allergies and was a diabetic. The resident was noted to have a peripherally inserted central catheter (PICC) line, had a Foley catheter and feeding tube. Review of the nursing progress note revealed no documentation was noted related to the resident's antibiotics or laboratory testing. Review of a progress note dated 09/20/24 at 2:05 P.M. (two days after admission) created by LPN #238 revealed a new order for IV antibiotics Vancomycin and Cefepime for six weeks due to osteomyelitis. Resident and pharmacy made aware of new orders. Labs also ordered weekly every Monday and to report labs (to physician) every Monday for six weeks. Review of Resident #139's physician orders for September 2024 revealed an order written on 09/20/24 for Vancomycin 1000 milligrams (mg)/200 milliliter (ml) every 12 hours. The resident had an order, dated 09/20/24 for Cefepime 2 grams (gm)/100 ml three times a day. Resident #139 also had labs orders written on this date for a Complete Blood Count (CBC), Erythrocyte Sedimentation Rate (ESR), C-Reactive Protein (CRP), test and a pre Vanco level every Monday with the start date of 09/23/24. The order noted for the lab results to be faxed to the physician. Review of the medication administration record for September 2024 revealed the resident received his first dose of Cefepime in the facility on 09/21/2024 at 6:00 A.M. (three days after admission) and his first dose of Vancomycin on 09/20/2024 at 9:00 P.M. (two days after admission). Record review revealed Registered Nurse (RN) #241 documented on the treatment administration record that the ordered laboratory testing was completed on both 09/23/24 and 09/30/24; however, there was no additional information contained in the resident's medical record to support this laboratory testing was actually completed. Review of a progress note dated 09/23/24 at 9:52 A.M. created by Unit Manger #118 revealed, called Nurse Practitioner #501 with infectious Disease for clarification of labs. Review of a progress note dated 09/24/24 at 1:22 P.M. created by Unit Manager #118 revealed, the unit manager spoke with Nurse Practitioner #501 with infectious disease, a new order was received for labs to start on 09/30/24. The note also included there was an order to fax to infectious disease. Review of a progress note dated 10/01/24 at 12:01 P.M. created by RN #241 revealed the lab was in to draw the resident's Vanco trough level. Lab drawn and taken to lab. Review of a progress note dated 10/01/24 at 2:07 P.M. created by RN #241 revealed critical lab called to this nurse for Vanco trough of 30.3 (elevated). Nurse Practitioner #501 with infectious disease notified. New order received to transfer resident to the emergency room . Nurse Practitioner #501 notified the local hospital. Review of the completed laboratory testing for Resident #139 (from admission through discharge) revealed the only lab that was completed was dated 10/01/24 which was for the Vanco trough level. The lab result was critically high with a reading of 30.3. Per information contained on the lab paperwork the normal range for a Vanco trough was between 10.0-20.0 microgram per milliliter. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital paperwork for Resident #139 dated 10/01/2024 revealed this resident had diagnoses of acute kidney injury (AKI), Vancomycin overdose, and PICC line complications. Continue review revealed the resident's creatinine level was elevated at 1.6 with a normal range between 0.7-1.3 mg/ml. (An elevated creatinine level indicated your kidneys weren't working properly). The resident's Vancomycin level was 30.9 and with the elevated creatinine level and monitoring needed to be completed. As of 10/06/24 the assessment and plan for the resident's osteomyelitis of the vertebra, sacral and sacrococcygeal region was that the patient was at a high risk due to requiring drug therapy, IV Vancomycin that required intense monitoring for toxicity, monitoring trough levels. Trough level noted to be at 30.9. Recommendations to discontinue Vancomycin due to toxicity and renal failure. Patient was stared on IV Daptomycin (antibiotic) in addition to continuing the IV Cefepime. For the AKI, the resident's renal function continued to worsen despite being on IV fluids with a creatinine level this morning of 3.12 from 2.95 and a Glomerular Filtration Rate (GFR) (blood test used to measure how well kidneys are filtering waste and extra fluid from the blood) rate from 21 to now 20. A GFR of 60 or higher was in the normal range. Below 60 may indicate kidney disease and below 15 may indicate kidney failure. This was suspected secondary to Vancomycin toxicity. The resident remained hospitalized as of 10/09/24. Interview on 10/07/24 at 10:40 A.M. with the DON revealed the facility contacted the infectious disease office to clarify the lab orders however, this was not done until 09/23/2024. The DON revealed she believed the facility had drawn labs on 09/30/24 and it resulted with a critical high Vanco trough level. The facility then received the order to send Resident #139 to the hospital and the rest of his ordered labs would be drawn there. A follow-up interview with the DON on 10/07/24 at 11:04 A.M. revealed when she reviewed the resident's hospital discharge instructions related to labs being completed weekly, the DON claimed they did not complete labs prior to 09/30/24 because they didn't have any orders to draw labs. When asked why staff did not call/obtain clarification prior to 09/23/24, the DON indicated she was not sure why no one called prior to that. The DON then verified the lab was not actually drawn on 09/30/24 as scheduled but was drawn on 10/01/2024. The DON also verified not all the scheduled labs were drawn for the resident following the hospitalization and she was not sure why only the Vanco trough was drawn on 10/01/24. Interview on 10/07/24 at 12:02 P.M. with RN #241 revealed she worked on 09/23/24 and marked the laboratory testing as completed because Resident #139 had a bandage that appeared like he had blood drawn and when she asked him if someone came and drew his labs, he said yes. RN #241 confirmed she had not received any resulted labs for 09/23/24 which normally results would come the same day. RN #241 also stated she had not drawn Resident #139's blood for lab work on 09/30/24 because she stated there was nothing in the system popping up to inform her this was scheduled to be done that day. Lab was contacted and they came to the facility and obtained the blood work on 10/01/2024 which resulted in the critical Vanco trough level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with Hospital Staff #500 on 10/07/24 at 3:12 P.M. revealed Resident #139 was discharged from the hospital to the skilled nursing facility on 09/18/24. On that day, the hospital nurse explained all the discharge orders to the facility nurse. The expectation was that the Vancomycin lab order (along with the other labs) were to be completed on Monday, 09/23/24. She stated she called the facility on 09/24/24 to find out what the Vancomycin lab results were. She spoke with Unit Manager #118, who confirmed the labs were not taken and stated she was told they would get them when the labs were due again on Monday, 09/30/24. She told Unit Manager #118 they would like the labs to be done the next day or Thursday (09/25/24 or 09/26/24); she stated they would get it done. There was also an order for the routine Vancomycin trough level (along with all the other labs ordered) to be done on Monday, 09/30/24. They first received lab results from the Vancomycin testing on 10/01/24 which was a critically high number, which was why they stated Resident #139 needed to go to the hospital. Hospital Staff #500 confirmed there were multiple dates in which the facility was to get labs completed, and they were not done. Interview with LPN #238 on 10/08/24 at 12:17 P.M. revealed she was going through the resident's discharge paperwork from the hospital for Resident #139 on 09/20/2024 and then contacted the hospital/physician (at that time) to discuss the resident's Vancomycin orders. She stated she wasn't sure if the resident was to continue the Vancomycin, so she called to clarify. The LPN stated she put the new order in for Vancomycin to continue and for the lab work to be done on each Monday. She stated she put the order in for lab work to be done on 09/23/24. When asked again why she made the call to clarify the orders (on 09/20/24), she stated she was looking at the discharge paperwork from the hospital. She stated she didn't know why the orders were not clarified on 09/18/24 when the resident was admitted . Attempts to reach LPN #250, the nurse who admitted the resident on 09/18/24, by telephone on 10/07/24 and 10/08/24 were unsuccessful. Review of the facility policy titled, Lab and Diagnostic Test Results-Clinical Protocol, revised 09/2012 revealed the physician would identify, and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff would process the test requisitions and arrange for the test. A nurse would review all results and the person who was to communicate results to the physician would review and be prepared to discuss any concerns or issues the physician will be expected to address upon receiving the results. This deficiency represents non-compliance investigated under Complaint Number OH00158452. This deficiency is also an example of continued non-compliance to the survey dated 08/29/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on observation, record review, insulin pen needle user guide review, facility policy review and interview, the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 14.8% and included 4 medication errors of 27 medication administration opportunities. This affected two residents (#17 and #61) of two residents observed during medication administration. The facility census was 137. Findings include: 1. Review of the medical record for Resident #17 revealed an initial admitted [DATE] with an re-entry date of 12/21/2023. Diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and seasonal allergies. Review of Resident #17's physician orders for October 2024 revealed an active order for Fluticasone Propionate HFA, Inhalation Aerosol 110 microgram (mcg)/actuation (ACT), Two puffs inhale orally two times a day for chronic obstructive pulmonary disease. Observation on 10/07/2024 at 8:10 A.M. of Licensed Practical Nurse (LPN) #310 completed medication administration for Resident #17 revealed the above noted medication was not available in the medication cart. LPN #310 claimed that maybe the medication was in the resident's room. Continued observation revealed LPN #310 administering Resident #17's other morning medication and when asked if she had inhaler in her room, Resident #17 claimed no, she was not able to keep it in her room. Interview on 10/07/2024 at 8:15 A.M. with LPN #310 confirmed Resident #17's Fluticasone Propionate inhaler was not available in the medication cart and therefore cold not be administered as ordered by the physician. 2. Review of the medical record for Resident #61 revealed an initial admitted [DATE] and a re-entry date of 08/08/2022. Diagnosis included type two diabetes mellitus with hyperglycemia, acute respiratory failure, and hypertension. Review of Resident #61's physician orders for October 2024 revealed an order for Allopurinol 100 milligram tablet given daily for gout, Tresiba FlexTouch pen-injector 100 units/milliliters; inject 15 units subcutaneously in the morning related to type two diabetes, and Mucinex (dextromethorphan) DM extended release 30-600 mg tablet give one tablet twice a day for COPD, cough and congestion. Observation on 10/07/2024 at 8:40 A.M. of LPN #386 administering medication to Resident #61 revealed the ordered Allopurinol and Mucinex medication was not available in the medication cart for administration. Continued observation revealed when LPN #386 was preparing the Tresiba Flex Pen for administration, the recommended two-unit prime was not completed after applying the flex pen needle and prior to dialing the dosage dial to the ordered 15 units. Interview on 10/07/2024 at 8:50 A.M. with LPN #386 confirmed the two medications were not available in the medication cart for administration and claimed that it was not required for the insulin pen needle to be primed prior to drawing up the order insulin dosage. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the insulin pen needle instruction guide, no date noted revealed under section titled Priming you Pen Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the Dose Knob to selection 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the Dose Knob in until it stops and 0 is seen in the Dose Window. Review of the facility policy titled, Administering Medication, dated 12/2012 revealed Medication shall be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00158141.