

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Luxe Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>Based on medical record review and staff interview, this facility failed to ensure residents responsible party participated in care planning. This affected one (Resident #279) of the five residents reviewed for care planning. The facility census was 134.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #279 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included heart disease, acute and chronic respiratory failure, seizures, and chronic obstructive pulmonary disease.</p> <p>Review of Resident #279's comprehensive baseline care plan which was developed with admission to this facility, revealed this care plan had not been reviewed with Resident #279 or this residents Power of Attorney(POA) as required.</p> <p>Interview on 04/01/25 at 2:30 P.M. with the Medical Records Director #262 confirmed the facility did not have a care plan on file indicating Resident #279's POA was informed or involved in the initial care planning. Medical Records Director #262 and the Director of Nursing both confirmed a signature is usually obtained when each care plan is developed from the resident themselves or the POA to help support they were apart of the planning.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163902.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>Based on medical record review, fall investigation review, staff interview, and facility policy review, this facility failed to ensure the appropriate resident representative was notified of a fall incident when it occurred. This affected one (Resident #285) of the five residents review for notification of change. The facility census was 134.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #285 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included dementia with behavioral disturbances, cognitive communication deficit, and schizoaffective disorder bipolar type. Resident #285's Power of Attorney (POA) was noted to be his wife.</p> <p>Review of the plan of care dated 03/27/23 and revised 03/19/25 revealed Resident #285 was at risk for falls related to dementia, reduced mobility, intermittent confusion, self care deficit, and difficulty walking. Interventions included to encourage to use urinal at bedside, encourage to attend activities that minimize the potential for falls while providing diversion and distraction, gripper socks to be worn when out of bed without shoes to decrease falls, if at fall risk, family or legal rep are given instructions about the interventions that are in place to reduce risk of fall, call light in reach, perimeter mattress, provide safe environment, PT and to treat as needed, and falling leaf placed outside door.</p> <p>Review of the progress note dated 01/27/25 at 5:15 A.M. created by Registered Nurse (RN) #58 revealed, Resident was observed lying on the floor face down. Assessed for mental status, vital signs and injury. Assisted times two to sit on the bed where laceration to forehead was cleaned and dressing applied. Denies any pain except when laceration was cleaned. Resident states he wants to sit in the chair and was assisted with two staff to the bathroom prior to being assisted to the chair.</p> <p>Review of the fall investigation completed 01/27/25 revealed Resident #285's daughter was notified of the fall on 01/27/25 at 8:00 A.M.</p> <p>Review of the progress note dated 01/28/25 at 9:10 A.M. created by RN #12 revealed, Interdisciplinary Team (IDT) met to discuss incident on 01/27/25 resulting in a fall. Resident stated that he was trying to get to his chair and fell . Power of Attorney (POA) and Physician notified. IDT agree on new intervention of wearing grippy socks when ambulating. Care plan updated. Care continues per current plan of care.</p> <p>Interview on 04/01/25 at 3:30 P.M. with Nurse Supervisor #48 confirmed Resident #285's daughter was not the POA and his wife was and the correct person was not notified of the fall that occurred in the early morning hours on 01/27/25 until the following day on 01/28/25.</p> <p>Review of the facility policy titled Fall Prevention and Management, dated 11/2024 revealed under section titled Post Fall, the nurse is to notify the Resident's physician and responsible party of the fall and new interventions.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00164213.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>41271</p> <p>Based on medical record review, staff interview, medication administration observation, and facility policy review, this facility failed to ensure their medication error rate was less than 5% when there was noted 5 medication errors of the 43 medication that was administered resulting in a 11.9% error rate. This affected three (Resident #33, #147, and #143) of the four resident observed for medication administration. The facility census was 134.</p> <p>Findings include:</p> <p>1. Observation on 04/01/25 from 8:40 A.M. through 8:45 A.M. of Licensed Practical Nurse (LPN) #8 administering medication to Resident #33 revealed the medication Aspirin (non-inflammatory drug) 81 milligrams (mg) chewable was administered with all other medications that were to be administered whole.</p> <p>Interview on 04/01/25 at 8:45 A.M. with LPN #8 confirmed Resident #33 was supposed to receive Aspirin 81 mg chewable tablet but this medication was not separated from other medications and consumed whole.</p> <p>2. Observation on 04/01/25 from 9:00 A.M. through 9:20 A.M. of LPN #300 administering medication to Resident #147 revealed all medication was administered whole and all at the same time.</p> <p>Review of the medical record for Resident #147 revealed an order for Phenytoin (anticonvulsant) 150 mg to be administered twice a day for seizures. This medication was noted to be a chewable tablet.</p> <p>Interview on 04/01/2025 at 9:20 A.M. with LPN #300 confirmed the chewable Phenytoin was given to Resident #147 whole and not separated to be chewed up.</p> <p>3. Observation on 04/01/2025 from 9:20 A.M. through 9:40 A.M. of LPN #300 administering medication to Resident #143 revealed all medication ordered was either crushed or capsules were pulled apart and the medication was placed in a medication cup and mixed with pudding for administration.</p> <p>Review of the medical record for Resident #143 revealed orders for Aspiring 81 mg Delayed Release (DR), Toprolxer (beta-blocker) Extended Release (ER), and Omeprazole (proton pump inhibitor to treat excess stomach acid) Delayed Release (DR).</p> <p>Interview on 04/01/2025 at 9:43 A.M. with LPN #300 confirmed all the medication for Resident #143 was either crushed or or taken out of the capsule and administered with pudding. LPN #300 confirmed delayed release, and extended release medication were not to be crushed or taken out of their capsules due to this medication then being absorbed too quickly.</p> <p>Review of the facility policy, no title and no date, revealed when preparing medication, double check the right medication, dose, route, and time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163902.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41271</p> <p>Based on medication administration observation, staff interview, and facility policy review this facility failed to ensure infection control measures were maintained while administering medication. This affected three (Resident #33, #147, and #143) of the four residents observed for medicating administration. The facility census was 134.</p> <p>Findings include:</p> <p>Observation on 04/01/2025 from 9:10 A.M. through 9:40 A.M. of Licensed Practical Nurse (LPN) #300 revealed after checking Resident #143's blood pressure, hand hygiene was not completed prior to starting to pull medication for the next resident. LPN #300 was then observed dropping medication for Resident #147 on the medication cart and then picking up the medication with an un-gloved hand and placing it back into the medication cup for administration. LPN #300 was then observed using un gloved hand to pull medication out of the cup prior to crushing this medication for administration.</p> <p>Interview on 04/01/2025 at 9:45 A.M. with LPN #300 confirmed she had checked Resident #143's blood pressure without completing hand hygiene prior to pulling medication for Resident #147 where there was a medication dropped on the medication cart which she picked up and placed in the medication cup as well as grabbing medication out the the medication cup with out implementing the proper infection control measures.</p> <p>Review of the facility policy, no title noted, no date noted revealed to never touch pills with bare hands to avoid contaminating or transferring oils, dirt, or germs onto the medication.</p>		