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	06/23/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, self-reported incident (SRI) review, and interview, the facility failed to complete thorough investigations after allegations of abuse. This had the potential to affect one resident (#131) of two residents reviewed for allegations of abuse. The facility census was 133. Findings include: Record review revealed Resident #131 admitted to the facility on [DATE] with diagnoses including seizures and other specified disorders of the brain. Review of a care plan last revised on 11/14/24 revealed Resident #131 did not have any behaviors. Review of a SRI investigation dated 05/11/25 revealed resident questionnaires were completed and Resident #131 indicated he had been mistreated. There was no evidence of any follow-up questions to determine how or when Resident #131 had been mistreated. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #131's cognition remained intact and he had no behaviors. Interview on 06/18/25 at 3:00 P.M. with the Director of Nursing (DON) confirmed the questionnaire completed by Resident #131 indicated he had been mistreated and a skin check was completed with no findings, but there was no evidence Resident #131 was asked questions to determine how or when he was mistreated. The DON confirmed investigations should be completed at the time such allegations are made. Review of a statement dated 06/18/25 by Resident #131 revealed he had not been mistreated. Review of a policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (dated 10/2022) revealed during the investigation, residents who were on the same unit the allegations were made should be interviewed as well as the resident who made the allegations. Mistreatment was defined as inappropriate treatment to the resident. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00166557.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, policy review, and guardian interview, the facility failed to have evidence that a transfer from the facility was necessary for the resident's welfare and the resident's needs could not be met in the facility. This affected one resident (#135) of three residents reviewed who were transferred to other nursing facilities. The facility census was 133. Findings include: Review of the closed medical record for Resident #135 revealed an admission date of 01/04/25 and diagnoses including Schizophrenia, hypertension, benign neoplasm of cranial nerves, and hearing loss. His brother was his legal guardian. Review of a Minimum Data Set (MDS) assessment completed 04/01/25 revealed he had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. It also indicated he was independent with mobility. An elopement assessment completed 01/04/25 indicated the resident was not at risk for elopement. Review of nursing progress notes revealed no evidence of any attempts to elope from the facility until 05/18/25. On 05/18/25 at 12:30 A.M. Registered Nurse (RN) #209 documented that Resident #135 exited the facility and was returned by facility staff. There was no further documentation in the medical record regarding the details of the elopement. Interview with the Administrator on 06/16/25 at 8:02 A.M. revealed the facility has a secured unit in the [NAME] building. (However, Resident #135 did not reside on the secured unit). All exit doors in the [NAME] and [NAME] buildings are locked against going out. The doors require a key card that staff carry or the receptionist near the front door of each building is able to unlock the front exit doors. The facility has a receptionist on duty for 10 hours each day (8:30 AM to 7:00 PM) in each building. Review of a QAPI Performance Improvement Project form dated 05/19/25 revealed a resident (Resident #135) eloped from the building while the fire panel was alarming. Root cause analysis: Lack of education of staff not knowing to supervise residents while the alarm was going off. All exit doors become unlocked while the fire panel alarmed. The resident pushed on a door and left. Goal and Objective: Once the fire panel alarms, staff will monitor units and exit doors until maintenance is alerted and addresses the alarm. Further review of the record revealed on 05/20/25 at 12:05 P.M. it was documented that a referral was sent to another nursing facility (a sister facility that was located approximately 170 miles, 2.5 hours away). There was no further information documented in the nursing progress notes until 05/29/25 at 8:25 A.M. when it was documented that discharge paperwork was completed, attached medication list, facesheet, and most recent labs. It did not indicate where the resident was discharged to. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Discharge Recap of care form signed by Registered Nurse (RN) #209 on 05/29/25 revealed Resident #135's primary language was Nepali. Date of discharge or transfer notice given to resident or representative: 05/23/25. discharge date : [DATE]. Facility transfer necessary for resident's safety with wandering. Reason for discharge/transfer: Necessary for the resident's welfare and the needs could not be met in the facility. Discharging to another SNF/long term care. The name of facility discharging to was the facility that the referral was sent to on 05/20/25. Who initiated discharge? Facility was check marked. Is this resident discharging while an appeal is in process? No was marked. Most recent BIMS score- 0. Does not display mood or behavior patterns. Both verbal and non verbal were marked. Local contact agency notified: No. Date of statement of appeal rights given to resident or representative: 05/29/25. There was no evidence in the record that the basis for the transfer/discharge was documented, why the resident's needs could not be met in the facility, or any attempts to meet the resident's needs. There was no documentation to indicate how the facility he was transferred to could better meet his needs or was different from the current facility (current facility with all locked doors). There was no evidence of any attempts to find a facility closer to the resident's guardian (facility transferred to is approximately 2.5 hours from the guardian). There was no evidence of any documentation by the physician about the basis for the transfer/discharge, what needs could not be met, efforts to meet those needs, and the specific services the receiving facility would provide to meet the needs of the resident that could not be met at the current facility. There was no evidence the facility involved the resident's guardian in choosing a facility to transfer to. Interview with Regional Administrator #352 on 06/17/25 at 8:55 A.M. revealed former Administrator #350 had spoken with Resident #135's brother and the brother had asked for a place that was better suited for him. Former Administrator #350 then told him of the sister facility that is 2.5 hours away. He stated the resident was transferred to the other facility as it was safer and a younger population. He gave no further information on how it was safer. He confirmed there was nothing documented in the medical record about the decision to transfer. Review of a note provided by the facility and signed by former Administrator #350, the Director of Nursing, and Assistant Director of Nursing #265 revealed a care conference was held with Resident #135's brother on 05/20/25 via phone regarding the issue that occurred on 05/18/25. The brother stated he was thankful for the great work the nursing staff did in getting his brother back to the building and ensuring his safety. He did mention if there was a building that would be able to handle his brother's needs more. We stated we have a sister facility and can send a referral there and see what happens. Explained the facility handles more mental health residents and is equipped with a more secure environment that would be appropriate for his needs. He stated he would like his brother to try it out. A referral will be sent today. Interview with former Administrator #350 on 06/17/25 at 12:31 P.M. confirmed she had spoken to Resident #135's brother. She stated that she had approached him with the idea to transfer. She stated she thought referrals to other facility's were done but she was not sure about where. She stated the facility he was transferred to was the only one that would take him. She confirmed she did not document in the medical record anything related to the transfer/discharge. She stated that it was a facility initiated discharge but the brother agreed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 06/17/25 at 3:22 P.M. confirmed, besides the note of referral to another facility, there were no notes related to the reason for the discharge, how his needs could not be met, attempts to meet needs, or how the new facility could meet his needs. She stated former Administrator #350 was the one who spoke to Resident #135's guardian. Interview with Resident #135's guardian on 06/16/25 at 3:39 P.M. revealed he did not want the resident to move from the facility. He stated the facility he was transferred to is too far for him to visit. He stated he now has to go 2-3 weeks between visits and has only seen him once since he was transferred. He stated the facility called him and said they can't take care of him anymore. He stated he felt like he did not have a choice in the transfer and the facility had already made the plans to transfer him to the facility that is 2.5 hours away. They said it was the only choice. He stated he went to visit for the first time recently and did not like the facility. He stated it was dirty and stunk. He stated he did not know how that facility is different or could meet his needs better. Review of the facility policy titled Facility Discharge and Transfer Policy (dated December 2024 and Revised January 2025) revealed the facility will only initiate a discharge or transfer of a resident for appropriate reasons, ensure proper documentation, provide advance notice, and facilitate coordination with receiving providers or services. Notice requirements include: written notice must be provided to the resident and representative at least 30 days in advance of a planned discharge or transfer, unless an emergency situation applies. Residents have the right to appeal an involuntary discharge. This deficiency represents non-compliance investigated under Complaint Number OH00166557.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, policy review, and guardian interview, the facility failed to provide notice before transfer to another facility to include the reason for the transfer and include appeal rights This affected one resident (#135) of three residents reviewed who were transferred to other nursing facilities. The facility census was 133. Findings include: Review of the closed medical record for Resident #135 revealed an admission date of 01/04/25 and diagnoses including Schizophrenia, hypertension, benign neoplasm of cranial nerves, and hearing loss. His brother was his legal guardian. Review of a Minimum Data Set (MDS) assessment completed 04/01/25 revealed he had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. It also indicated he was independent with mobility. An elopement assessment completed 01/04/25 indicated the resident was not at risk for elopement. Review of nursing progress notes revealed no evidence of any attempts to elope from the facility until 05/18/25. On 05/18/25 at 12:30 A.M. Registered Nurse (RN) #209 documented that Resident #135 exited the facility and was returned by facility staff. There was no further documentation in the medical record regarding the details of the elopement. Interview with the Administrator on 06/16/25 at 8:02 A.M. revealed the facility has a secured unit in the [NAME] building. (However, Resident #135 did not reside on the secured unit). All exit doors in the [NAME] and [NAME] buildings are locked against going out. The doors require a key card that staff carry or the receptionist near the front door of each building is able to unlock the front exit doors. The facility has a receptionist on duty for 10 hours each day (8:30 A.M. to 7:00 P.M.) in each building. Review of a QAPI Performance Improvement Project form dated 05/19/25 revealed a resident (Resident #135) eloped from the building while the fire panel was alarming. Root cause analysis: Lack of education of staff not knowing to supervise residents while the alarm was going off. All exit doors become unlocked while the fire panel alarmed. The resident pushed on a door and left. Goal and Objective: Once the fire panel alarms, staff will monitor units and exit doors until maintenance is alerted and addresses the alarm. Further review of the record revealed on 05/20/25 at 12:05 P.M. it was documented that a referral was sent to another nursing facility (a sister facility that was located approximately 170 miles, 2.5 hours away). There was no further information documented in the nursing progress notes until 05/29/25 at 8:25 A.M. when it was documented that discharge paperwork was completed, attached medication list, facesheet, and most recent labs. It did not indicate where the resident was discharged to. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Discharge Recap of care form signed by Registered Nurse (RN) #209 on 05/29/25 revealed Resident #135's primary language was Nepali. Date of discharge or transfer notice given to resident or representative: 05/23/25. discharge date : [DATE]. Facility transfer necessary for resident's safety with wandering. Reason for discharge/transfer: Necessary for the resident's welfare and the needs could not be met in the facility. Discharging to another SNF/long term care. The name of facility discharging to was the facility that the referral was sent to on 05/20/25. Who initiated discharge? Facility was check marked. Is this resident discharging while an appeal is in process? No was marked. Most recent BIMS score- 0. Does not display mood or behavior patterns. Both verbal and non verbal were marked. Local contact agency notified: No. Date of statement of appeal rights given to resident or representative: 05/29/25. There was no evidence in the record that the basis for the transfer/discharge was documented. There was also no evidence that before transfer, the resident's guardian was provided notice of transfer with the reason, effective date, location of transfer, appeal rights and Ombudsman information. Interview with Regional Administrator #352 on 06/17/25 at 8:55 A.M. revealed former Administrator #350 had spoken with Resident #135's brother and the brother had asked for a place that was better suited for him. Former Administrator #350 then told him of the sister facility that is 2.5 hours away. He stated the resident was transferred to the other facility as it was safer and a younger population. He gave no further information on how it was safer. He confirmed there was nothing documented in the medical record about the decision to transfer. Review of a note provided by the facility and signed by former Administrator #350, the Director of Nursing, and Assistant Director of Nursing #265 revealed a care conference was held with Resident #135's brother on 05/20/25 via phone regarding the issue that occurred on 05/18/25. The brother stated he was thankful for the great work the nursing staff did in getting his brother back to the building and ensuring his safety. He did mention if there was a building that would be able to handle his brother's needs more. We stated we have a sister facility and can send a referral there and see what happens. Explained the facility handles more mental health residents and is equipped with a more secure environment that would be appropriate for his needs. He stated he would like his brother to try it out. A referral will be sent today. Interview with former Administrator #350 on 06/17/25 at 12:31 P.M. confirmed she had spoken to Resident #135's brother. She stated that she had approached him with the idea to transfer. She stated she thought referrals to other facility's were done but she was not sure about where. She stated the facility he was transferred to was the only one that would take him. She confirmed she did not document in the medical record anything related to the transfer/discharge. She stated that it was a facility initiated discharge but the brother agreed. She confirmed a discharge notice with required information was not provided to the guardian. Interview with the Director of Nursing on 06/17/25 at 3:22 P.M. confirmed, besides the note of referral to another facility, there were no notes related to the reason for the discharge. She stated former Administrator #350 was the one who spoke to Resident #135's guardian. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #135's guardian on 06/16/25 at 3:39 P.M. revealed he did not want the resident to move from the facility. He stated the facility he was transferred to is too far for him to visit. He stated he now has to go 2-3 weeks between visits and has only seen him once since he was transferred. He stated the facility called him and said they can't take care of him anymore. He stated he felt like he did not have a choice in the transfer and the facility had already made the plans to transfer him to the facility that is 2.5 hours away. They said it was the only choice. He stated he went to visit for the first time recently and did not like the facility. He stated it was dirty and stunk. He stated he did not know how that facility is different or could meet his needs better. He confirmed he was not provided with a discharge notice, information on how to appeal, or contact information for the Ombudsman. Review of the facility policy titled Facility Discharge and Transfer Policy (dated December 2024 and Revised January 2025) revealed the facility will only initiate a discharge or transfer of a resident for appropriate reasons, ensure proper documentation, provide advance notice, and facilitate coordination with receiving providers or services. Notice requirements include: written notice must be provided to the resident and representative at least 30 days in advance of a planned discharge or transfer, unless an emergency situation applies. Residents have the right to appeal an involuntary discharge. This deficiency represents non-compliance investigated under Complaint Number OH00166557.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 2. Record review revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including dementia, muscle weakness, and hypertension. Review of a quarterly MDS 04/01/25 revealed Resident #18 had moderately impaired cognition and had no behaviors. Review of a care plan updated on 06/14/25 revealed Resident #18 was at risk for falls related to cognitive function, decreased mobility, current hospital stay, weakness, acute chronic encephalopathy, hypertension, hypocalcemia, cognitive impairment, and self-care deficit with a goal to be free from injury. Interventions included but were not limited to keep urinal at bedside (06/14/25), place a bedside toilet in room (06/04/25), and a please call don't fall sign in room (02/23/25). Observation on 06/18/25 at 12:34 P.M. revealed Resident #18 was sitting in his bed, eating. Resident #18 did not have a urinal at bedside, a bedside toilet, or a please call don't fall sign in his room. Interview on 06/18/25 at 1:28 P.M. with DON confirmed the fall interventions were not in place at the time of the survey. Review of a policy titled Fall Prevention and Management dated 11/2024 revealed post fall, the facility will assess the resident, investigate and determine the root cause of the fall, and notify the resident's physician and responsible party of the fall and new interventions. This deficiency represents non-compliance investigated under Master Complaint Number OH00166557 and Complaint Number OH00166254. Based on observations, record review, review of a facility investigation, and staff interviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent an elopement for Resident #135 and to prevent falls for Resident #18. This affected one of three residents reviewed for elopement (Resident #135) and one of four residents reviewed for falls (Resident #18). The facility census was 133. Findings include: 1. Review of the closed medical record for Resident #135 revealed an admission date of 01/04/25 and diagnoses including Schizophrenia, hypertension, benign neoplasm of cranial nerves, and hearing loss. His brother was his legal guardian. Review of a Minimum Data Set assessment completed 04/01/25 revealed he had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. It also indicated he was independent with mobility. An elopement assessment completed 01/04/25 indicated the resident was not at risk for elopement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress notes revealed no evidence of any attempts to elope from the facility until 05/18/25. On 05/18/25 at 12:30 A.M. Registered Nurse (RN) #209 documented that Resident #135 exited the facility and was returned by facility staff. There was no further documentation in the medical record regarding the details of the elopement. Review of a facility investigation timeline titled Elopement of Resident #135 05/18/25 revealed the following: 05/18/25 at 12:10 A.M. Staff doing rounds noticed the resident was missing. Fire Panel alarming. 05/18/25 at 12:20 A.M. A staff nurse driving by and saw resident walking. Called the facility nurse and said she is bringing the resident back to the facility. 05/18/25 at 12:25 A.M. Staff nurse and nursing assistant escorted the resident back into the building. Fire panel continued to buzz/alarm. 05/18/25 12:40 A.M. Staff nurse assessed the resident for injury and no injuries noted. Staff nurse called on call nurse manager and explained what happened. Resident was immediately placed on 1:1. 05/18/25 at 1:00 A.M. Fire department showed up. Maintenance also showed up. 05/18/25 at 1:15 A.M. Total house head count was completed. All residents present and accounted for. Egress doors checked and all locking properly. Staff interviews conducted. Cause of elopement determined to be the resident eloped out of the [NAME] wing door while the fire panel was buzzing/alarming, allowing all doors to be unlocked. 05/18/25 at 2:00 A.M. Whole house education started. 05/19/25 Maintenance completed all egress door audit to ensure in proper working order. 05/19/25 Whole house elopement risk assessments started. 05/19/25 Updated elopement risk assessments and reported to QAPI team. 05/19/25 Elopement books updated. 05/19/25 Elopement audits started. Interview with the Administrator on 06/16/25 at 8:02 A.M. revealed the facility has a secured unit in the [NAME] building. (However, Resident #135 did not reside on the secured unit). All exit doors in the [NAME] and [NAME] buildings are locked against going out. The doors require a key card that staff carry or the receptionist near the front door of each building is able to unlock the front exit doors. The facility has a receptionist on duty for 10 hours each day (8:30 am to 7 pm) in each building. Review of the schedule for 05/17/25 (included staff working after midnight to include 05/18/25) revealed there was one nurse and one nursing assistant scheduled for the 200 hall on [NAME] where Resident #135 resided. This included Licensed Practical Nurse (LPN) #199 and Nursing Assistant #187. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation reports revealed there was not a statement from LPN #199 regarding the elopement of Resident #135. A written witness statement from Nursing Assistant #187 only stated that she was doing a round, came up front to the stock room and last saw Resident #135 eating snacks and watching tv in the front room. The time of the incident was noted to be 11:00 P.M. to 11:30 P.M. There was no statement regarding the actual elopement. There were two other staff witness statements as part of the investigation. LPN #201 documented that she was the nurse on the 400 hall of [NAME] that night and was passing medications on her hall. No further information provided. Nursing Assistant #191 (who was working the night shift on 100 hall of [NAME]) stated she last saw Resident #135 in the lobby at 10:00 P.M. Review of a QAPI Performance Improvement Project form dated 05/19/25 revealed a resident eloped from the building while the fire panel was alarming. Root cause analysis: Lack of education of staff not knowing to supervise residents while the alarm was going off. All exit doors become unlocked while the fire panel alarmed. The resident pushed on a door and left. Goal and Objective: Once the fire panel alarms, staff will monitor units and exit doors until maintenance is alerted and addresses the alarm. Maintenance will then make sure the doors are locked once the fire alarm is set back in place. Action items included: Educate the staff on what to do when the fire alarm panel is going off. Complete whole house elopement assessments on all residents. Update elopement books with residents new scores. Audit staff response towards fire panel buzzing/alarming five times a week on different shifts for four weeks. Maintenance to ensure all egress doors are in proper working order. All estimated completion dates were 05/19/25 except education estimated completion 05/26/25 and audits of staff response estimated completion 06/19/25. Resident #135 was transferred to another facility on 05/29/25. Review of a log of the fire alarm panel provided by the alarm monitoring company revealed no evidence of any issues with the fire alarm system until 05/18/25 at 12:23 A.M. when a trouble alarm was noted (The facility timeline indicated that the fire panel was alarming at 12:10 A.M. when Resident #135 was noted missing and the resident was escorted back into the building at 12:25 A.M.). The log further indicated a fire alarm activated on 05/18/25 at 1:26 A.M. (after Resident #135 was already back in the facility). The following staff interviews were conducted by the surveyor: a. Interview with Registered Nurse (RN) #190 on 06/17/25 at 8:48 A.M. (worked on [NAME] 100 hall on the night of the elopement) revealed he did not know Resident #135 was gone until LPN #199 told him and the resident was already back. He stated she told him after midnight but he did not remember when and did not know how the resident got out. He stated he did not hear the fire alarm at all that night. He did not remember maintenance or the unit manager coming in that night. b. Interview with LPN #201 on 06/17/25 at 9:00 A.M. (worked on [NAME] 400 hall on the night of the elopement and had provided a written statement noted above) revealed the nurse working on 200 hall in the [NAME] building (RN #231) had told her Resident #135 was outside around midnight and he was still out. She was told that RN #248 was bringing some food to RN #231 and saw Resident #135 outside. RN #248 called RN #231 and said she was bringing him back. LPN #201 stated she did not know how he got out. She stated the fire alarm had went off however there was no sound and only the strobe lights were flashing. She stated she did not know what time that was. She stated she did not know if the fire department was there and she did not see maintenance that night. (continued on next page)

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	365344	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe Rehabilitation and Care Center	957 Becks Knob Road Lancaster, OH 43130

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Interview with RN #231 on 06/17/25 at 10:17 A.M. revealed she was routinely the night shift supervisor but on the night Resident #135 eloped, she worked the floor on 200 hall in the [NAME] building. She stated she was not aware Resident #135 was gone until RN #248 called her and said she saw the resident near the train tracks close to the [NAME] grocery store. (Approximately 1.8 miles from the facility). She stated RN #248 was not working that night but was bringing her some food. RN #231 stated she then notified Resident #135's nurse (LPN #199) that the resident had eloped. She stated LPN #199 was not aware that he was gone. RN #248 then brought the resident back to the facility. RN #231 stated she went to the parking lot and was there when RN #248 brought him back in her car. She stated she then told LPN #199 to call the unit manager and she went back to the [NAME] building. She stated she did not know how the resident got outside. She stated the fire alarm did not go off until 30 minutes after the resident returned. She stated she did not know if the fire department came that night. She stated maintenance did come in and shut off the alarm. e. Interview with RN #248 on 06/17/25 at 10:31 A.M. revealed she was not working the night of 05/17-05/18/25. She stated she was on her way to the facility to drop off something to a nurse around 12:30 A.M.-12:45 A.M. when she saw a person walking that she thought looked like Resident #135. She stated she verified it was him. She stated he was near the train tracks across the road from the [NAME] grocery store. She stated she then called RN #231. She stated she got Resident #135 into her car and took him back to the facility. She stated it took about five minutes to return. She stated when she got to the facility parking lot, RN #231 and Nursing Assistant #187 were there but not LPN #199. The resident was taken inside the building. f. Interview with Nursing Assistant #187 on 06/17/25 at 2:53 P.M. revealed she and LPN #199 were working on the unit where Resident #135 resided on the night of 05/17/25 into 05/18/25. She stated she last saw Resident #135 in the lobby eating snacks between 11:00 P.M. and 12:00 A.M. She stated she was doing rounds and noticed that he was not in his room. She stated she went up front to look for him and could not find him. She stated her and LPN #199 were looking for the resident when RN #248 showed up with him around 12:00 A.M. She stated she was not sure how he got out of the facility. She stated some residents go out to smoke but must be let out by staff. She stated she did not remember letting anyone out. She stated staff sometimes go out to smoke or for breaks. She stated she did not go out at all that night. She stated the nurse goes out to smoke sometimes. She did not mention the fire alarm until questioned by the surveyor. She stated the fire alarm had went off in the other building ([NAME]) but not in the [NAME] building. She stated she did not know when the alarm went off. She stated she was not aware that the exit doors release if the fire alarm goes off. g. Interview with Unit Manager RN #209 on 06/23/25 at 7:46 A.M. revealed she was on call the weekend Resident #135 eloped. She stated LPN #199 called her around 12:30 P.M. and said he got out but was back in the facility. She stated she lives close and came in around 12:50 A.M. She stated when she arrived an alarm was going off on the fire alarm panel in the [NAME] building. She stated it was not the main fire alarm going off. She stated the fire department was there in the [NAME] building when she arrived. She stated maintenance came in also. She stated she thought he got out the door that was unlocked due to the alarm. She stated Resident #135 was placed on 1-1 staffing. She stated she stayed about two hours then went home. She verified that the monitoring company log did not indicate trouble with the system until 12:23 A.M. (Resident #135 was already back to the facility at 12:30 A.M. per her interview). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of facility open payables log, review of Administrator job description, and interviews, the facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently including compliance with all financial obligations for the delivery of care to attain and maintain the highest practicable well being of each resident. This affected 133 of 133 residents residing in the facility. Findings include: 1. Review of information received from two anonymous complaints on 06/11/25 revealed: 1: The facility did not get the food truck because they did not pay the bill and 2: Food service was cut off until payment was made as the facility owed $86,000.00. a. Interview with Dietary Aide #294 on 06/16/25 at 9:35 A.M. revealed the food delivery truck did not come on Friday 06/06/25 to deliver the facility food supply. She stated they had to change the menu over the weekend but the facility had sufficient food. She stated the food delivery truck then came on Tuesday 6/10/25 with a food delivery. b. Interview with Dietary Manager #234 on 06/16/25 at 9:38 A.M. revealed the food delivery truck did not come on Friday 06/06/25. She stated the facility normally gets food delivery's on Tuesdays and Fridays. She stated the delivery did not come on 06/06/25 due to the bill not being paid. She stated a check was sent to the food delivery company (Sysco) and food delivery service resumed on 06/10/25. She confirmed the menu had to be altered between 06/07/25 and 06/10/25 as the planned menu items were not available. c. Interview with Business Office Manager (BOM) #287 on 06/16/25 at 3:10 P.M. revealed the facility uses an outside company to pay their vendor bills. She stated the vendor invoices come in the mail or by email. She then uploads them into the system and they go to the outside company that pays the bills. She stated she had no way to know the total amount owed to any vendor, including the food supply vendor. Interview with BOM #287 on 06/23/25 at 1:30 P.M. revealed she had no invoices available to show how much was owed to the food supply company or the last payments made. d. Interview with Account Manager #351 for Sysco (Food suppliers to facility) on 06/17/25 at 1:29 P.M. revealed he needed to get permission to provide information to the State Survey Agency regarding how much the facility owed on their food supply invoices or any other information related to food delivery service. As of 06/23/25, Sysco did not reply with any information regarding how much the facility owed on their food service bill or if there was a potential for food delivery service to be suspended again. e. Facility Regional Administrator #352 provided a log of vendor open payables dated 06/17/25. It indicated that the facility owed $25,863.41 for the past 0-30 days and $35,047.97 for the past 31-60 days for a total of $60,911.38 to Sysco, the food supply vendor. As of 06/23/25 at 3:10 P.M., the facility did not provide any Sysco invoices for amounts due and did not provide any evidence of the last time payments were made to Sysco for food service. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. Review of the undated Administrator job description revealed the general responsibilities of the administrator included: Ensure compliance with Local, State, and Federal Regulations, ensure safety for the residents and employees, monitor the staffing and PPD budgeted for each department, make facility rounds every day and follow up on any concerns or issues, and negotiate contracts and rates with the providers and vendors with CEO approval. This deficiency represents non-compliance investigated under Complaint Number OH00166557.