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	12/31/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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

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	12/31/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents' medical records were complete and accurate to reflect correct information on the location and origin of a pressure ulcer and treatments were properly documented in the medical record when completed. This affected two (#58 and #135) of eight residents reviewed. Findings include: 1.Review of Resident #58's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a non-traumatic subarachnoid hemorrhage, acute and chronic respiratory failure, tracheostomy status, and gastrostomy status. Review of Resident #58's physician's orders revealed he had orders in place to receive tracheostomy care every shift and prn. He was also to receive a treatment to his peg tube site cleaning it with normal saline, patting dry, and applying a split gauze every shift. Review of Resident #58's treatment administration record (TAR) for December 2025 revealed the nurse working night shift did not document any treatments being completed on the TAR for 12/13/25, 12/17/25, 12/22/25, or 12/23/25. All the boxes the nurse should have initialed to show evidence of treatments being completed were left blank. Findings were verified by the Director of Nursing (DON). On 12/29/25 at 3:25 P.M., an interview with the DON revealed she was able to determine the same nurse worked all the night shifts in December 2025 when the TAR for that month had missing initials indicating treatments had been completed as ordered. She spoke to the nurse and confirmed the treatments were done and the nurse just failed to include that documentation into the electronic TAR. She indicated the nurse was still somewhat new to the facility and had apologized for not initialing the TAR to show the treatments had been done. She provided a printed copy of the TAR, after she had the nurse initial in the boxes for the above dates that were previously left blank, to show the treatment had been completed. She acknowledged the electronic TAR was missing several initials showing treatments had been completed as ordered before she had the nurse add the initials for those dates. She provided evidence that the nurse who later initialed the TAR did in fact work on those dates when the TAR was not initialed. Time sheets showed Registered Nurse (RN) #166 was the nurse working the resident's hall on the night shift when those initials were missing. She acknowledged residents' medical records should be accurate and complete and show all treatment received on a particular shift. 2. Review of Resident #135's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a stroke due to an embolism (clot) of the right, middle cerebral artery, chronic respiratory failure with hypoxia, tracheostomy status, and unspecified protein-calorie malnutrition. She had a peg tube placed to receive enteral nutrition due to her not receiving any food by mouth. Review of a nurse's progress note by Licensed Practical Nurse (LPN) #231 revealed he was called to Resident #135's room by an aide when the resident was noted to have new areas to the right and left buttock. A complete head to toe assessment was completed with measurements obtained of both areas and the facility's wound nurse practitioner was made aware of the new skin issues. New orders were received for the resident not to wear depends while in bed and to cleanse the bilateral buttocks with soap and water, pat dry, and apply Triad paste every shift and as needed (prn) for incontinence. Review of an interdisciplinary team (IDT) note dated 11/10/25 at 1:26 P.M. by LPN #229 (facility's wound nurse) revealed the IDT met in regard to Resident #135 having moisture associated skin dermatitis (MASD) to the left buttock and a pressure ulcer to the right buttock. The resident was not able to state what happened due to cognitive decline. They agreed with assisting the resident with turning and repositioning as needed and the care plan was updated. Review of Resident #135's care plans that were initiated during her stay and remained in place until her discharge from the facility on 11/18/25 revealed she had two separate care plans that both addressed her skin impairment. One care plan for the resident having an actual area of skin impairment related to her being bedbound revealed she had a Stage II (a partial thickness skin loss where the outer layer and part of the later beneath were damaged appearing as a shallow open sore with a red or pink wound bed) and MASD to her left buttock. She had another care plan for an impaired skin integrity as evidenced by MASD to the right buttock and a Stage II pressure ulcer to the left buttock. The two care plans were contradictory or one another changing the type and the location of the resident's skin impairment. Review of a skin grid pressure assessment dated [DATE] revealed Resident #135's Stage II pressure ulcer to the right buttock was indicated to be present upon admission, when it was not noted until 11/09/25. It also identified the original date of the pressure ulcer as being 11/02/25, instead of 11/09/25, when it was first noted. Review of a progress note from the wound nurse practitioner the facility consulted for wound management revealed she

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	12/31/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	12/31/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 appropriate personal protective equipment (PPE) was worn during tracheostomy care of a resident in enhanced barrier precautions (EBP's) for a medically invasive device. They also failed to ensure staff performing tracheostomy care and treatment of a peg tube site performed proper hand hygiene, after removing disposable gloves, and before touching environmental surfaces in the resident's room. This affected one (#58) of one resident reviewed for tracheostomy care. Findings include: Review of Resident #58's medical record revealed he was admitted to the facility on [DATE]. He had diagnoses that included acute and chronic respiratory failure, tracheostomy (an artificial airway established by surgically placing a plastic tube through the front of the neck) status, and gastrostomy (surgical placement of a tube through the abdomen and into the stomach for the administration of a liquid nutritional supplement for feeding purposes) status. Review of Resident #58's physician's orders revealed the resident had an order in place for tracheostomy care to be provided every shift and as needed (prn). He also had an order to cleanse his peg tube site with normal saline, pat dry, and apply a split gauze every shift and was receiving treatment to venous ulcers of his left inner and outer ankle. On 12/30/25 at 2:16 P.M., a treatment observation was completed for Resident #58's tracheostomy care and the treatment of his peg tube site. The treatment was provided by Licensed Practical Nurse (LPN) #170 and she was assisted by Registered Nurse (RN) #194. LPN #170 was the unit manager and RN #194 was the nurse assigned to work the floor on that date. Resident #58's door to his room was noted to have a sign that identified him as being on EBP's. There was PPE hanging on the outside of the door for the staff to use when providing care to the resident. Neither of the two nurses donned any PPE before entering the room or when performing tracheostomy care/ treatment of the peg tube site. Both nurses were next to the resident's bed as they performed tracheostomy care and the resident was noted to be coughing during the procedure to include suctioning of the resident during three separate attempts. The resident was also observed coughing with the removal of his inner cannula. After removing the resident's inner cannula, LPN #170 realized that she did not have the proper size of the inner cannula she had to re-insert into his tracheostomy. She was observed to remove her gloves, without performing hand hygiene, and was noted to rummage through a box in the room that contained the resident's extra respiratory supplies to locate the inner cannula of the proper size. She was not able to locate the proper size inner cannula in the resident's room. RN #194 was noted to remove the old split gauze dressing from around the resident's peg tune site to allow the surveyor to observe the stoma and skin around the peg tube's insertion site. She disposed of the old split gauze dressing and was asked by LPN #170 to leave the resident's room to retrieve the proper sized inner cannula needed to complete the tracheostomy care. RN #194 was observed to remove her disposable gloves she had on when removing the old split gauze dressing, without performing hand hygiene, and before leaving the resident's room. It was not until RN #194 returned to the resident's room, that both nurses performed hand hygiene by washing hands with soap and water before donning gloves to resume insertion of the inner cannula. On 12/30/25 at 2:29 P.M., an interview with LPN #170 confirmed that she and RN #194 did not don any additional PPE when they entered the room of Resident #58 to perform tracheostomy care to the resident, despite it being known that the resident was in EBP's. She confirmed the resident had a sign on the outside of his door identifying him as being on EBP's and he also had PPE hanging on the outside of his door. She stated they should have donned a gown, gloves, mask, and face shield when performing tracheostomy care to the resident since they were up against the side of his bed and was performing a procedure that promoted him to cough while they were in close proximity. She also confirmed that she did not perform hand hygiene, after she removed her gloves, and when searching his room for the proper size of the inner cannula she needed to complete his tracheostomy care. She acknowledged removing gloves did not negate the need to perform hand hygiene before touching other environmental surfaces or supplies in the resident's room. On 12/30/25 at 2:37 P.M., an interview with RN #194 confirmed she did not perform hand hygiene, after she removed her disposable gloves, following her handling Resident #58's split gauze dressing, and before she left the room to obtain the proper size of the inner cannula LPN #170 needed to complete his tracheostomy care. She acknowledged the removal of disposable gloves did not negate the need to perform hand hygiene before coming in contact with environmental surfaces with her potentially contaminated hands. She further acknowledged the nurses should have donned additional PPE, other than