

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and observations, the facility failed to maintain comfortable hot water temperatures and homelike environment. This affected 13 residents (Resident #11, #13, #19, #23, #50, #59, #74, #83, #90, #99, #121, #122, #135) residing on the 200 unit and 16 residents (Resident #29, #40, #43, #61, #67, #69, #71, #91, #102, #125, #126, #128, #136, #142, #149, #150) on the 300 unit located in the facility's [NAME] home due to uncomfortable hot water temperatures and room [ROOM NUMBER] located in the facility's [NAME] home affecting Resident #14 due to hot water not working properly and to ensure room [ROOM NUMBER] where Resident #155 resided was free of deep black gouges on the floor. The facility census was 148. Findings include: 1. Interview on 03/30/2026 at 9:35 A.M. with Certified Nursing Assistant (CNA) #254 revealed the hot water tank located on the 200 unit on the [NAME] Wing has been turned off to the resident's rooms due to there being a leak. CNA #254 claimed that per her knowledge this leak has not been addressed or fixed yet. The shower room located on this unit still had hot water and did not affect their ability to provide bathing care for residents. Interview on 03/30/2026 at 9:40 A.M. with Environmental and Safety Director (ESD) #225 revealed the hot water for the 200 unit on the [NAME] Wing has been turned off for about two weeks due to a leak. There was a leak in the plumbing a while ago and they had to areas of the concrete floor up to fix it and now there has been another leak in the flooring. Due to having to dig up the concrete flooring, they were trying to get in touch with a plumbing company that had the special equipment to see the plumbing through the concrete floor so they could locate the exact area where the leak is at. ESD #225 claimed he has reached out to two different places to see if they can find someone who has specific equipment. According to the two companies ESD #225 had reached out to, they are booked out and could not give a timeframe to come in and evaluate the leak. Call placed on 03/30/2026 at 10:35 A.M. to one of the plumbing companies which ESD #225 had reached out to and provided the contact number for claimed 03/30/2026 was the first time they received a phone call from ESD #225. This company owner claimed the contact number listed online for customers was directly to his personal cell phone and he was the only one who answered this phone. Anyone who called had the ability to leave a voice message and this mailbox was checked frequently. Observation completed on 03/30/2026 at 11:00 A.M. of the 200 hall located on the [NAME] Wing confirmed there was no hot water being delivered to residents' room [ROOM NUMBER]-212. The 200 hall on [NAME] wing was a secured memory care unit (for residents with memory impairment) where 13 residents lived including Rooms 201-212 and Residents #11, #13, #19, #23, #50, (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: 365344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#59, #74, #83, #90, #99, #121, #122, #135. 2. Observations on 03/24/26 at 8:07 A.M. in room [ROOM NUMBER] on [NAME] Wing (Resident #40) and on 03/24/26 at 8:20 A.M. in room [ROOM NUMBER] on [NAME] Wing (Resident #29) revealed the hot water felt cool to touch in the sinks in the resident bathrooms. On 03/30/26 at 8:20 A.M. interview with Environmental and Safety Director (ESD) #225 revealed he was not aware of any issues with the hot water on the 300 hall on [NAME] wing. He stated the hot water in the resident rooms and the hot water in the shower room on the 300 hall were controlled by two different hot water tanks. A check of the hot water in the sink in room [ROOM NUMBER] (Resident #40) on 03/30/26 at 8:35 A.M. verified with ESD #225's thermometer and the surveyor's thermometer revealed the hot water was 71 degrees and the hot water in the sink in room [ROOM NUMBER] (Resident #29) at 8:36 A.M. was 73.4 degrees with ESD #225's thermometer and between 72 and 74 degrees with surveyor thermometer. A check of the hot water in the shower in the shower room on the 300 hall [NAME] wing at 8:40 A.M. revealed the hot water was 91.4 degrees with ESD #225's thermometer. (The sink in the shower room had hot water). A check of the hot water in room [ROOM NUMBER] on [NAME] wing on 03/30/26 at 8:55 A.M. with surveyor thermometer revealed the hot water in the sink was 72 degrees. ESD #225 stated the hot water should be between 105-120 degrees. He further stated that it was either a bad element or a bad fuse in the hot water tank causing the resident rooms not to have hot water. Interview with Nursing Assistant #252 on 03/30/26 at 8:45 A.M. revealed she had worked on the 300 hall [NAME] wing the prior week on 03/25/26 and the hot water was just luke warm. Resident #40 and #29 had impaired cognition and were not able to be interviewed to determine if they had concerns from the lack of hot water. The 300 hall on [NAME] wing was a secured memory care unit (for residents with memory impairment) where 16 residents lived including Rooms 300-314 and Residents #29, #40, #43, #61, #67, #69, #71, #91, #102, #125, #126, #128, #136, #142, #149, and #150. Interview with ESD #225 on 03/30/26 at 9:00 A.M. revealed that, after checking, there was a blown element and a popped fuse that was the cause of no hot water in the resident rooms on 300 hall [NAME] wing. On 03/30/26 at 9:40 A.M. he stated that, after adjusting the mixing valve for the shower unit on 300 hall [NAME] wing, he was able to get the hot water up to 101 degrees. 3. Observations on 03/23/26 at 2:14 P.M. revealed the floor in room [ROOM NUMBER] (Resident #155) on [NAME] Wing had multiple dark dirty looking areas upon entering the room and by the resident's recliner. It looked at though someone had used a black marker and made long, black marks on the tile flooring. Observations on 03/30/26 at 10:10 A.M. with ESD #225 in room [ROOM NUMBER] on [NAME] wing revealed ESD #225 confirmed there were multiple black marks covering at least six of the one foot tiles in the center of the room. He stated these marks were actually cuts in the tile in the floor caused by moving the bed around in the room. It was observed that the black marks were actually cuts in the tile and were not cleanable. ESD #225 stated that, due to the amount of tiles affected, the whole flooring needed to be replaced in the room. He stated he was not aware of how long the floor had been that way. (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #14's medical record revealed the resident was admitted [DATE] and had diagnoses that included quadraplegia, depression, and anxiety. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact. Observation of Resident #14's bathroom sink on 03/26/2026 at 9:15 A.M. revealed water barely trickled from the faucet when hot water was turned on. Interview with Environmental and Safety Director (ESD) #225 on 03/26/2026 at 9:18 A.M. confirmed the hot water in Resident #14's bathroom sink did not work.		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to complete required minimum data set (MDS) assessments in a timely manner for Residents #7, #15, #60, and #147, failed to ensure the initial wound assessment accurately reflected wound characteristic for Resident #157, and failed to ensure the comprehensive assessment was accurate for Resident #8. This affected six (Resident #7,#8,#15,#60,#147, and #157) of the 36 residents sampled for the annual survey. The facility census was 148. Findings include: 1. Review of Resident #7's medical record revealed an admission date of 05/30/25, a re-entry date of 02/11/26 and diagnoses including but not limited to cerebral infarction, anxiety disorder, chronic kidney disease stage four, major depressive disorder, diabetes, and dementia. Review of Resident #7's admission MDS dated [DATE] revealed a completion date of 03/02/26. In an interview on 03/30/26 at 1:10 P.M. MDS Coordinator #292 confirmed Resident #7's admission MDS was not completed until 03/02/26. 2. Review of Resident #15's medical record revealed an admission date of 09/02/25 and diagnoses including but not limited to alcohol abuse, cannabis dependence, and hypertension. Review of Resident #15's quarterly MDS dated [DATE] revealed a MDS completion date of 03/02/26. In an interview on 03/26/2026 at 11:45 A.M. MDS Coordinator #292 confirmed Resident #15's quarterly MDS was not completed until 03/02/26. 3. Review of Resident #60's medical record revealed an admission date of 12/19/25, a re-entry date of 01/17/26 and diagnoses including but not limited to end stage renal disease, diabetes, and hypertension. Review of Resident #60's admission Minimum Data Set (MDS) dated [DATE] revealed a completion date of 01/12/26. In an interview on 03/26/26 at 11:45 A.M. MDS Coordinator #292 confirmed Resident #60's admission MDS was not completed until 01/12/26. 4. Review of Former Resident #147's medical record revealed an admission date of 11/02/25, a discharge date of 02/28/26 and diagnoses including but not limited to paraplegia, unspecified, depression, and hypertension. Review of Former Resident #147's quarterly MDS dated [DATE] revealed a MDS completion date of 01/23/26. In an interview on 03/31/2026 at 10:53 A.M. MDS Coordinator #292 confirmed Former Resident #147's quarterly MDS was not completed until 01/23/26. (continued on next page)		

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 04/07/2026
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)		
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, dated October 2025 revealed the MDS completion date for a quarterly assessment must be no later than 14 days after the Assessment Reference Date (ARD) (ARD + 14 calendar days). Further review revealed the MDS admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. Review of the policy titled MDS Completion and Submission Timeframes, revised July 2024 revealed the timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. 5. Review of the medical record for Resident #157 revealed an initial admission date of 03/19/26 with the diagnoses including but not limited to dementia, anxiety disorder, abnormal weight loss, urinary tract infection, fracture of lower leg and senile degeneration of brain. Review of the resident's admission assessment with baseline care plan dated 03/19/26 revealed the resident was admitted to the facility with a stage III pressure ulcer to her sacrum measuring 11 centimeters (cm) by 0.5 cm by 0.1 cm and an unstageable pressure ulcer to the left gluteal fold that measured 0.5 cm by 1.0 cm. Further review revealed no comprehensive assessment reflecting the condition of the wound, type of dressing and a description of the wound. Review of the plan of care dated 03/19/26 revealed the resident has impaired skin integrity as evidenced by stage III pressure ulcer to sacrum and an unstageable pressure to left gluteal fold. Interventions included low air loss mattress in place and pressure redistribution device in chair. Review of the progress note dated 03/19/26 revealed the admission head to toe assessment was completed and the resident was admitted to the facility with a stage III pressure ulcer to her sacrum and an unstageable to her left gluteal fold. Review of the resident's monthly physician orders for March 2026 identified orders dated 03/19/26 barrier cream after each incontinence episode, cleanse stage III pressure ulcer to sacrum with normal saline (NS), pat dry, apply triad paste and cover with foam dressing, cleanse unstageable pressure ulcer to left gluteal fold with normal saline, pat dry, apply triad paste and leave open to air twice daily, 03/20/26 enhanced barrier precautions (EBP) due to wounds every shift, 03/24/26 low air loss mattress on bed for pressure reduction, monitor low air loss mattress functioning and check that the settings are appropriate for the resident every shift. On 03/25/26 at 10:07 A.M., an interview with the Director of Nursing (DON) verified the stage III pressure ulcer and the unstageable pressure ulcer was not comprehensively assessed on admission. Review of the facility policy titled, Skin and Wound Management, dated 01/25 revealed the nurse will conduct a comprehensive skin assessment upon admission including skin integrity. In addition, the nurse shall describe and document/report the following, full assessment of pressure injury including location, state, length, width, and depth, presence of exudates or necrotic tissue, pain assessment, resident's mobility status and current treatments, including support surfaces. 6. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction due to occlusion or stenosis of small artery, hypertension, and (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	post-traumatic stress disorder (PTSD). Review of the Trauma Informed Care Assessment verified PTSD screen was marked no for Resident #8 on 08/26/26, 11/26/25 and 02/27/26. The Minimum Data Sheet Assessment (MDS) dated [DATE] indicated PTSD as an active diagnosis. Interview with Social Services Director #366 on 03/26/26 at 12:10 P.M. verified the Trauma Informed Care Assessment PTSD screen was marked no for Resident #8 on 08/26/25, 11/26/25 and 02/27/26. Social Services Director #366 confirmed Resident #8 had diagnosis of PTSD upon admission.		

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 04/07/2026
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, observations, and facility policy review, this facility failed to provide activities to meet the interest or needs of each resident residing on the facility's memory care units. This affected all 29 resident's (Resident # 11, 13, 19, 23, 29, 40, 43, 50, 59, 61,67, 69, 71, 74, 83, 90, 91, 99, 102, 121, 122, 125, 126, 128, 135, 136, 142, 149, 150) residing on the 200 and 300 unit in the [NAME] Wing. The facility census was 148. Findings include: 1 The facility had a secured memory care unit on 200 hall of [NAME] wing where 13 residents resided: Residents #11, 13, 19, 23, 50, 59, 74, 83, 90, 99,121, 122, 135. Review of the activity calendar for the memory care unit revealed on 03/25/26 chats were scheduled for 10:00 A.M. No activity was observed at 10:00 A.M. Observations on 03/25/26 at 11:30 A.M. on the 200 hall memory care unit revealed direct care staff actively assisting residents with Activity of Daily Living (ADL) care. Multiple residents were observed ambulating independently on the 200 unit. Interview with Nursing Assistant #249 on 03/25/26 at 2:36 P.M. revealed she had worked at the facility for 5-6 months and normally works dayshift. She stated there was no activity schedule or plan for the unit. She stated the activity aides were supposed to provide the activities for residents on the unit. Observations on 03/25/26 at 2:45 P.M. revealed no activities occurring on the 200 hall memory care unit. (2:00 P.M. was to be snack and chat and 2:30 P.M. was to be bible study per activity calendar). Interview with Activity Assistant #264 on 03/25/26 at 3:00 P.M. revealed that the activity scheduled every day of March 2026 at 10:00 A.M. called chats for the memory care units was done by someone else other than activities. She stated it was not a group activity. She stated someone just walks through and says hey. Interview with Activity Director #326 on 03/25/26 at 3:06 P.M. revealed the memory care units (200 and 300 halls on [NAME] Wing) have different activity schedules than the rest of the facility. She confirmed there are four staff who work in activities. She stated two of those staff do primarily memory care and work either 11:00 A.M. to 7:30 P.M. or 12:00 P.M. to 8:30 P.M. She stated most days through the week there are a total of three staff in activities for the whole building and two on the weekends. She confirmed that the memory care activity calendar has the same four activities scheduled every day of the month of March: 10:00 A.M. Chats; 11:00 A.M. Lunch and tunes; 12:30 P.M. exercise; and 2:00 P.M. snack and chat. She stated the aides on the unit do the 10:00 A.M. chats. She stated no one did the 11:00 A.M. lunch and tunes today. She stated the activity aide did not come on duty until noon. She stated she just took over as activity director four weeks ago and did not make the calendars. She stated if an activity does not work, the staff should try a different one. She stated the memory care units should have a lot of engagement with residents to keep them busy and occupied. She stated they should have a variety of activities. She stated that she knew that the residents on the units liked music, puzzles, coloring, and movies. Interview with Activity Director #326 on 03/25/26 at 3:06 P.M. revealed current events and room visits are done simultaneously and last about 5-10 minutes. (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations completed 03/30/26 from 4:10 P.M. through 4:40 P.M. of the 200 unit on the [NAME] Wing revealed no activity was being completed. Per review of the activity Calander, karaoke was supposed to be completed at 4:00 P.M. Interview with the Activity Director #326 on 03/30/2026 at 4:43 P.M. revealed there was two evening aides one for each of the memory care units. The Activity Director #326 claimed one of the activity aides were supposed to be on the 200 unit doing Karaoke and could not provide an explanation why this activity was not completed or where that activity aide was during that time. 2. The facility had a secured memory care unit on 300 hall of [NAME] wing where 16 residents resided: Residents # 29, 40, 43, 61, 67, 69, 71, 91, 102, 125, 126, 128, 136, 142, 149, and 150. Review of the record for Resident #29 revealed an admission date of 02/09/26 and diagnoses including vascular dementia and cerebral infarction. A Minimum Data Set assessment completed 02/15/26 revealed a score of 00 for the brief interview for mental status, indicating severe cognitive impairment. It indicated he required set up assistance only with eating and was independent with mobility. Review of an Activity Interview Form completed 02/09/26 revealed Resident #29 wished to participate in group and independent activities and go on outings. It stated he had present interests in: reading/books, religion/bible study, reminiscing, tv/radio. movies/videos, cooking/food, sports, and bingo. It stated he wished for visits by clergy in the facility. Review of a daily preference evaluation completed 02/09/26 revealed that it was very important to him to be around animals such as pets, go outside to get fresh air, and participate in religious activities. Observations on 03/24/26 at 9:54 A.M. Resident #29 was observed sitting in the lounge with two other residents. There were no staff in the room and no activities going on. The aide was sitting across the hall in the dining room looking at her phone screen. Review of the memory care activity schedule revealed on 03/24/26 at 10:00 A.M. AM chats were scheduled. There was no activity observed at 10:00 A.M. on 03/24/26. Observations on 03/24/26 at 4:23 P.M. revealed Resident #29 to be sitting in the dining room on the secured unit. A staff person was doing one female resident's nails. No other activity going on. Review of the memory care activity schedule revealed on 03/24/26 at 4:00 P.M. nails was scheduled. Observations on 03/25/26 at 9:03 A.M. revealed Resident #29 was laying in bed awake. The television was on in the room but you could not see the screen from his bed due to the bathroom door being open. There were no activities going occurring on the 300 hall secured unit. Two male residents were observed sitting quietly in the dining room (no staff and no activities). One of the male residents then started raising his voice to the other resident and said get out of here. He said the resident was making noise and that he agitated him. A staff person came in and took one of the residents out of the dining room. Observations on 03/25/26 at 9:58 A.M. revealed Resident #29 to be in bed with eyes closed. There (continued on next page)		

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 04/07/2026
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were no activities occurring on the 300 hall unit. There was one aide working on the 300 hall unit and she was standing in the hall leaning up against the wall. The nurse was observed sitting in the nurses station room. There were no activity staff on the unit. Review of the activity calendar for the memory care unit revealed on 03/25/26 chats were scheduled for 10:00 A.M. No activity was observed at 10:00 A.M. Observations on 03/25/26 at 11:30 A.M. on the 300 hall memory care unit revealed a nursing assistant sitting in the lounge alone looking at her phone screen. Another aide was in the dining room with five residents. As soon as the surveyor walked in, the aide moved quickly and started asking residents if they wanted to color a paper heart. Resident #29 was not present. He was observed in bed at 11:33 A.M. with his eyes closed. Observations on 03/25/26 at 2:23 P.M. on the 300 hall secured unit revealed Resident #29 to be standing in the hallway. There were no activities occurring. Review of the activity calendar for the memory care unit for 03/25/26 revealed snack and chat was to occur at 2:00 P.M. and bible study was to occur at 2:30 P.M. Interview with Nursing Assistant #249 on 03/25/26 at 2:36 P.M. revealed she had worked at the facility for 5-6 months and normally works dayshift. She was working on the 300 hall memory care unit. She stated there was no activity schedule or plan for the unit. She stated the activity aides were supposed to provide the activities for residents on the unit. She stated there was an activity aide on the unit now (was sitting in the lounge talking with her prior to the interview) but she had not done any activities. She stated there had not been any activities on the 300 hall memory care unit that day. Observations on 03/25/26 at 2:45 P.M. revealed no activities occurring on the 300 hall memory care unit. (2:00 P.M. was to be snack and chat and 2:30 P.M. was to be bible study per activity calendar). Interview with Activity Assistant #201 on 03/25/26 at 2:45 P.M. revealed activities scheduled for the 300 hall memory care unit that day included: 10:00 A.M. chats. She stated she did not know who did that activity. She stated she did snack and chat at 2:00 P.M. (however, observations did not reveal any activity going on at 2:23 P.M.). She stated she was supposed to do bible study at 2:30 P.M. which would include watching a video or praying. She stated that activity had not occurred yet. She stated there are four staff who work in activities (for the whole 172 bed facility). She stated some days there are only three staff in activities, due to days off. She stated she and another activity aide provide the activities for the two secured memory care units on [NAME] wing (200 and 300 halls). She stated the other 1-2 staff provide the activities for the rest of the facility. She stated there are only two staff scheduled on the weekends for activities from 8:00 A.M. to 4:30 P.M. She stated Resident #29 will participate in activities such as exercises or painting. Interview with Activity Assistant #264 on 03/25/26 at 3:00 P.M. revealed that the activity scheduled every day of March 2026 at 10:00 A.M. called chats for the memory care units was done by someone else other than activities. She stated it was not a group activity. She stated someone just walks through and says hey. Interview with Activity Director #326 on 03/25/26 at 3:06 P.M. revealed the memory care units (200 and 300 halls on [NAME] Wing) have different activity schedules than the rest of the facility. She confirmed there are four staff who work in activities. She stated two of those staff do primarily (continued on next page)		

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 04/07/2026
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	memory care and work either 11:00 A.M. to 7:30 P.M. or 12:00 P.M. to 8:30 P.M. She stated most days through the week there are a total of three staff in activities for the whole building and two on the weekends. She confirmed that the memory care activity calendar has the same four activities scheduled every day of the month of March: 10:00 A.M. Chats; 11:00 A.M. Lunch and tunes; 12:30 P.M. exercise; and 2:00 P.M. snack and chat. She stated the aides on the unit do the 10:00 A.M. chats. She stated no one did the 11:00 A.M. lunch and tunes today. She stated the activity aide did not come on duty until noon. She stated she just took over as activity director four weeks ago and did not make the calendars. She stated if an activity does not work, the staff should try a different one. She stated the memory care units should have a lot of engagement with residents to keep them busy and occupied. She stated they should have a variety of activities. She stated that she knew that the residents on the units liked music, puzzles, coloring, and movies. Review of the activity participation records for Resident #29 since admission [DATE]) revealed that he had only current events and room visits marked for 23 of 30 days. There was no evidence of any activities that included his preferences: pets, clergy visits, going outside, or bingo. Interview with Activity Director #326 on 03/25/26 at 3:06 P.M. revealed current events and room visits are done simultaneously and last about 5-10 minutes. Review of the facility policy dated 2001 and revised June 2018 titled Activity Programs revealed activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. All activities are documented in the resident's medical record. Our activity programs consist of individual, small group, and large group activities that are designed to meet the needs and interests of each resident.		

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 04/07/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, observations, and facility policy review, this facility failed to provide care and services related to pressure ulcer care. This affected 5 residents (Resident #11, #57, #108, #138, and #157) of the 7 residents reviewed for wound care. The facility census was 148. Findings include: 1 Review of the medical record for Resident #11 revealed an admission date of 12/19/2025. Diagnoses included rhabdomyolysis, wedge compression fracture of the thoracic vertebra, and Dementia. Review of plan of care dated 12/28/2025 revealed Resident #11 was noted to have impaired skin integrity as evidenced by a unstageable pressure to the coccyx, and wound to the right and left heels. Interventions include to apply protective barrier cream after each incontinence episode, turn and reposition as needed, provide medication as ordered. notify nurse of any new pressure areas, apply a pressure redistribution device to the bed and chair. Review of the skin assessment dated [DATE] revealed Resident #11 was admitted to the facility with a pressure wound to the coccyx. Review of the skin assessment dated [DATE] revealed Resident #11 was noted to still only have a pressure wound to the coccyx. Review of the skin assessment dated [DATE] revealed Resident #11 had a pressure wound to the coccyx which was noted upon admission to the facility. Resident #11 was also noted to have a pressure wound to the right and left heel. Original date identified for the right and left heel was dated 12/28/2025. Review of Resident #11's physician orders for December 2025 revealed no evidence that treatments orders were implemented when the pressure wounds were noted to this resident's right and left heels. Treatments for both heels were not noted to be implemented until 12/30/2025. Review of Resident #11's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Resident #11 was noted to be free from any upper or lower extremity impairment and was independent for bed mobility. Interview on 03/25/2026 at 10:14 A.M. with the Director of Nursing (DON), Licensced Practical Nurse (LPN) Wound Nurse #388, and LPN #284 revealed Resident #11 admitted to this facility with only the coccyx wound. The heel wounds were identified on 12/28/25. LPN #284 was working the weekend this resident's heel wounds were identified and contacted the on-call physician who provided treatment orders. These orders were never implemented into this resident's medical record. LPN Wound Nurse #388 was interviewed and verified Resident #11 did not have any actual preventive interventions in place to protect her heels other than a pressure relieving mattress. When asked why the moon boots which were not ordered until March 2026 were not implemented upon wounds to the bilateral heels being identified, no answer was provided. 2. Review of Resident #57's physicians orders, revealed an order dated 04/23/2024 for an air mattress to bed, check placement and function every shift for pressure relief. (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment dated [DATE] revealed that Resident #57 had cognitive loss and was mobile with a wheelchair but dependent with showering/bathing, dressing, rolling, sitting to lying/lying to sitting, sitting to stand and all transfers. Review of Resident #57's care plan revealed that the resident had a potential for skin integrity/pressure ulcer development related to reduced mobility, incontinence, chairbound, terminal illness and hospice status. Interventions noted the resident required an air mattress to the bed for skin integrity, pressure relieving/reducing device on bed and/or chair, and assistance with activities of daily living (ADL) and mobility needs. Review of the progress noted dated 12/26/2025 for Resident #57 revealed a Braden Scale for predicting pressure ulcer risk of 12.0. Observation of Resident #57 on 03/23/2026 at 11:27 A.M. revealed Resident #57 resting in bed with air mattress settings of normal and 140 pounds. Review of Resident #57's chart revealed a weight of 85.9 pounds on 03/04/2026. Interview with Licensed Practical Nurse (LPN) #219 revealed that Resident #57's air mattress was set to the wrong weights, but that hospice provides the air mattresses and maintains them. Observation of Resident #57's air mattress on 03/24/2026 at 11:17 A.M. revealed that the settings were corrected to appropriate weight. 3. Record review revealed Resident #138 was admitted on [DATE] with diagnoses including but not limited to dementia, major depressive disorder, psychotic disorder with hallucinations, anxiety disorder, morbid obesity and quadriplegia. Review of Resident #138's physician orders dated 10/08/2024 revealed a Braden scale for predicting pressure ulcer risk of 12.0. Review of Resident #138's MDS assessment dated [DATE] revealed cognitive intact with impairment on bilateral upper and lower extremities. Resident was dependent with rolling side to side, sitting to lying, lying to sitting and all transfers. Review of Resident #138's care plan revealed that the resident has a potential for pressure ulcer development and the potential for impairment to skin integrity related to immobility, quadriplegia and incontinence. Interventions included an air mattress with bolsters & check function every shift and requirement of pressure relieving/reducing device on bed and/or chair. Review of Physicians orders for Resident #138 revealed an order dated 02/11/2026 for a low air loss mattress on bed for pressure reduction, monitor low air-loss mattress functioning and check that the settings are appropriate for the patient every shift. Review of Resident #138's medical records reviewed a weight of 216.1 pounds on 03/04/2026. Observation of Resident #138 on 03/23/2026 at 1:28 P.M. revealed resident in bed on back with air mattress settings of alternate and 600 pounds to 1,000 pounds. (continued on next page)		

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 04/07/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Licensed Practical Nurse (LPN) #219 revealed that Resident #138's air mattress was set to the wrong weight, but that hospice provides the air mattresses and maintains them. Observation of Resident #138's on 03/24/2026 revealed air mattress settings at appropriate weight for resident. 4. Review of the medical record for Resident #157 revealed an initial admission date of 03/19/26 with the diagnoses including but not limited to dementia, anxiety disorder, abnormal weight loss, urinary tract infection, fracture of lower leg and senile degeneration of brain. Review of the resident's admission assessment with baseline care plan dated 03/19/26 revealed the resident was admitted to the facility with a stage III pressure ulcer to her sacrum measuring 11 centimeters (cm) by 0.5 cm by 0.1 cm and an unstageable pressure ulcer to the left gluteal fold that measured 0.5 cm by 1.0 cm. Further review revealed no description of the either wound. The assessment indicated the resident weighed 132.8 pounds. Review of the resident's Braden scale dated 03/19/26 revealed a score of 16 indicating the resident was at risk for skin breakdown. Review of the plan of care dated 03/19/26 revealed the resident has impaired skin integrity as evidenced by stage III pressure ulcer to sacrum and an unstageable pressure to left gluteal fold. Interventions included low air loss mattress in place and pressure redistribution device in chair. Review of the progress note dated 03/19/26 revealed the admission head to toe assessment was completed and the resident was admitted to the facility with a stage III pressure ulcer to her sacrum and an unstageable to her left gluteal fold. Review of the brief interview for mental status (BIMS) evaluation dated 03/20/26 revealed a score of six out of 15 indicating the resident had a severe cognitive deficit. Review of the resident's monthly physician orders for March 2026 identified an order dated 03/24/26 low air loss mattress on bed for pressure reduction, monitor low air loss mattress functioning and check that the settings are appropriate for the resident every shift. On 03/24/26 at 8:36 A.M., observation of Resident #157 revealed she was positioned on her back with no off-loading to the stage III pressure ulcer to the sacrum and the unstageable pressure ulcer to the left gluteal fold. Further observation revealed the low air loss mattress was set to firm. On 03/24/26 at 8:44 A.M., an interview with Registered Nurse (RN) #237 verified the mattress was set on firm and providing no off-loading to the stage III and the unstageable pressure ulcer. The RN revealed the resident weighed 132.8 pounds and should be set between 100 to 150 pounds. 5. Review of the medical record for Resident #108 revealed an initial admission date of 08/23/23 with the latest readmission date of 03/02/26 with the diagnoses including but not limited to hypoxemia, diabetes mellitus, chronic kidney disease, disappearance and death of family member, open wound to right hip, post-traumatic stress disorder, insomnia, anemia, paraplegia, hyperlipidemia, retention of urine, diabetes mellitus, mild intellectual disabilities, chronic pain, end stage renal disease, paranoid schizophrenia, major depressive disorder, benign prostatic hyperplasia, bladder neck obstruction, obstructive and reflux uropathy, kidney transplant status, spinal stenosis, need for assistance with (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal care and chronic obstructive pulmonary disease. Review of the plan of care dated 12/18/24 revealed the resident required the use of an air mattress due to potential and history of pressure ulcers and impaired skin integrity. Interventions included adjust settings when weights obtained by utilizing the setting graph on the air mattress pump. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The resident required substantial/maximal assistance with bed mobility. The assessment indicated the resident was at risk for skin breakdown and had no unhealed pressure ulcers. The facility implemented the interventions pressure reducing device bed/chair, nutrition or hydration intervention to manage skin problems, surgical wound care and application of ointments/medications other than to feet. Review of the resident's monthly physician orders for March 2026 identified orders dated 03/02/26 low air loss mattress. On 03/24/26 at 9:11 A.M., observation of the resident revealed his air mattress was set on the weight setting of 318 pounds. On 03/24/26 at 9:15 A.M., an interview with Registered Nurse (RN) #415 verified the resident air mattress was not set at the correct setting for the resident's weight. Review of the facility policy titled, Skin and Wound Management, dated 01/25 revealed nurses will ensure orders, interventions and treatments for skin and wounds are implemented as ordered.		

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 04/07/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and facility policy review, this facility failed to ensure a food steam table located on the [NAME] Wing was free from buildup, ensure the snack fridge located at the [NAME] nurses station had open food items that were properly dated and failed to prepare food in a sanitary manner in the [NAME] Wing. This had to potential to affect 147 residents residing at this facility as one resident who was noted to receive nothing by mouth (NPO). The facility census was 148. Findings include: Observations completed on 03/30/2026 at 10:30 A.M. of Dietary Manager #211 preparing pureed food for lunch revealed multiple concerns related to handling food in a safe and sanitary manner. Dietary Manager #211 was observed placing a pair of gloves on after completing hand hygiene. Three breadsticks were torn into smaller pieces by this same staff member with gloves hands then placed in [NAME] to be blended into a pureed texture. Dietary Manager #211 proceeded to walk over to the storage closet located in the kitchen to obtain a 2-ounce (oz) spoon to measure each breadstick serving. After letting the blender run for a few moments, Dietary Manager #211 removed the lid and used the 2 oz spoon to scrape food from the upper side of the blender container. A large amount of pureed bread was stuck to the spoon and Dietary Manager #211 was observed using her gloved hand to remove this bread from the spoon. Continued observation revealed Dietary Manager #211 completed hand hygiene then placed on a new pair of gloves. Dietary Manager #211 was then observed picking up multiple bowls of salad, uncovering each bowl and then using her gloved hands to scrap the salad into the blender container. After turning on the blender for a few moments, Dietary Manager #211 used a spoon to scrape the sides of the container and then placed the spoon back onto a metal table. This action was completed two additional times until the salad was at the appropriate pureed texture. Interview on 03/30/2026 at 10:50 A.M. with Dietary Manager #211 confirmed she had initially completed hand hygiene and placed a new pair of gloves on before she tore the breadsticks into smaller pieces but did not complete hand hygiene after touching multiple surfaces in the kitchen including a storage room door handle, and the door itself. Also confirmed after touching multiple surfaces, hand hygiene was not completed prior to using her gloved hand to scrap pureed bread of a spoon. Dietary Manager #211 also confirmed that she had used gloved hands to scrape the salad out for multiple bowl after touching different surfaces while obtaining the salad bowls along with using a spoon that was placed on a bare table to scrap purees salad off the side of the blender container. A barrier should have been placed on the table prior to placing the spoon on the tablet and she should not have used her gloved hands to scrape the salad out of each bowel. Observation of the [NAME] kitchen on 03/23/26 at approximately 8:45 A.M. and on 03/25/26 at 10:17 A.M. revealed the four empty water pans on the steam table had a heavy build up of tan limescale or mineral deposits. (water pans hold the water to create steam to keep food hot). Interview with Dietary Manager #211 on 03/23/26 at approximately 8:45 A.M. confirmed the build up of mineral deposits in the steam table pans. She stated they needed to be cleaned with a de-[NAME] that they would need to get from maintenance. Interview on 03/30/26 at 7:20 A.M. with Licensed Practical Nurse (LPN) #287 identified the refrigerator at the nurses station on [NAME] Wing as being a refrigerator used to store resident snacks/food items. (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 03/30/26 at 7:20 A.M. of the refrigerator revealed a large, unlabeled, plastic container of applesauce that was dated 01/04/26 (written on). It did not have a use by date or expiration date. The applesauce was then thrown away by LPN #287. There was also a plastic storage bowl full of spaghetti with room [ROOM NUMBER] written on it (Resident #153). The spaghetti was not dated. LPN #287 stated the resident's family had brought it in. He confirmed it was not dated to determine when it should be used by. There was also a sticky substance spilled inside the refrigerator on the shelves that items on the shelves were stuck to. All of the above was confirmed by LPN #287 at the time of the observation. Review of the facility policy dated 2001 and revised March 2022 and titled Foods Brought by Family/Visitors revealed food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility prepared food. The nursing staff will discard perishable foods on or before the use by date.		

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 04/07/2026
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)		
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews and facility policy review, the facility failed to honor bathing preferences. This affected one resident (#108) of one resident reviewed for choices. The facility census was 148. Findings Include: Review of the medical record for Resident #108 revealed an initial admission date of 08/23/23 with the latest readmission date of 03/02/26 with the diagnoses including but not limited to chronic kidney disease, post-traumatic stress disorder, paraplegia, retention of urine, diabetes mellitus, mild intellectual disabilities, chronic pain, end stage renal disease, paranoid schizophrenia, major depressive disorder, spinal stenosis, need for assistance with personal care and chronic obstructive pulmonary disease. Review of the plan of care dated 12/18/24 revealed the resident required assistance with showering and the resident was to be showered per facility protocol weekly. Review of the resident's admission assessment with baseline plan of care dated 11/19/25 revealed the resident preferred showers in the morning. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated it was very important to choose between a tub bath, shower, bed bath or sponge bath. On 03/25/26 at 3:20 P.M., an interview with Certified Nursing Assistant (CNA) #306 revealed the resident was scheduled for a shower every Tuesday and Friday. He said all residents who reside on the hallway were capable of being assisted to the central shower room for a shower. CNA #306 verified the facility only staffed one CNA for the 400 hallway and had to go to another hallway and get assist for those residents who require two staff members. CNA #306 verified those residents who required two staff members had longer wait times for assistance and at times showers are not provided due to the lack of staff assigned to the hallway. Review of the resident's bath and skin report from January 2026 revealed the resident had nine opportunities for a shower. Further review revealed the resident had a shower on 01/03/26, 01/20/26 and 01/24/26 and on 01/06/26, 01/10/26, 01/13/26, 01/17/26, 01/27/26 and 01/31/26 the resident received a bed bath. Review of the resident's bath and skin report from February 2026 revealed the resident had eight opportunities for a shower. Further review revealed the resident was given a bed bath on all dates scheduled for a shower. Review of the resident's bath and skin report from March 2026 revealed the resident had seven opportunities for a shower to date. Further review revealed the resident was given a bed bath on all dates scheduled for a shower. On 03/24/26 at 9:03 A.M., an interview with Resident #108 revealed he prefers a shower, however since he was bed bound and requires two assist he was provided bed baths. On 03/26/26 at 11:41 A.M., an interview with Licensed Practical Nurse (LPN) #287 verified the resident was given a bed bath instead of his preferred shower. Review of the facility policy titled, Resident Rights, dated 02/21 revealed federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right of self-determination.		

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 04/07/2026
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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview and facility policy review, the facility failed to notify the resident's representative of a change in condition. This affected one resident (#12) of 36 sampled residents. The facility census was 148. Findings Include: Review of the closed medical record for Resident #12 revealed an initial admission date of 02/03/26 with the diagnoses including but not limited to anemia, cystocele, osteoarthritis, diabetes mellitus, overactive bladder, chronic kidney disease, dementia, urinary tract infection, uterovaginal prolapse, spinal stenosis, osteoporosis, Alzheimer's disease and adult failure to thrive. Review of the resident's admission assessment with baseline plan of care dated 02/03/26 revealed the resident was alert and oriented to her name only. The resident was admitted to the facility with an indwelling urinary catheter for urinary obstruction and cystocele with prolapse. Review of the resident's bowel and bladder evaluation dated 02/05/26 revealed the resident had a urethral catheter due to cystocele with prolapse. The assessment indicated the resident was always continent of bowel and required extensive assistance from one staff member for toileting needs. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident required substantial/maximal assistance with toileting. The resident had an indwelling urinary catheter and was frequently incontinent of bowel. Review of the progress note dated 02/10/26 at 4:30 A.M. revealed the resident removed her indwelling urinary catheter and stated, I didn't want this in me anymore. The physician was notified and a new indwelling urinary catheter was reinserted. Review of the medical record revealed no documented evidence the resident's power of attorney (POA) was notified of the removal of the indwelling urinary catheter by the resident. Review of the progress noted dated 02/22/26 revealed the resident removed her indwelling urinary catheter. The physician was notified and ordered to leave the catheter out and monitor. Review of the medical record revealed no evidence the POA was notified the catheter was ordered to be left out. On 03/26/26 at 4:30 P.M., an interview with the Administrator verified the resident's POA was not notified the resident had pulled her indwelling urinary catheter out on 02/10/26 and the discontinuation of the indwelling urinary catheter on 02/22/26. Review of the facility policy titled, Change in Condition Policy, dated 09/24 revealed the facility will promptly identify, assess and respond to any significant change in a resident's physical, mental or psychosocial condition. The licensed nurse will ensure timely notification of the physician and resident representative and implement appropriate interventions to maintain the resident's health and safety. This deficiency represents non-compliance investigated under Complaint Number 2799805.		

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 04/07/2026
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)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, medical record review, interview and facility policy review, the facility failed to provide privacy during wound care. This affected one resident (#157) of one resident reviewed for privacy. The facility census was 148. Findings Include: Review of the medical record for Resident #157 revealed an initial admission date of 03/19/26 with the diagnoses including but not limited to dementia, anxiety disorder, abnormal weight loss, urinary tract infection, fracture of lower leg and senile degeneration of brain. Review of the resident's admission assessment with baseline care plan dated 03/19/26 revealed the resident was admitted to the facility with a stage III pressure ulcer to her sacrum measuring 11 centimeters (cm) by 0.5 cm by 0.1 cm and an unstageable pressure ulcer to the left gluteal fold that measured 0.5 cm by 1.0 cm. Further review revealed no description of the either wound. Review of the plan of care dated 03/19/26 revealed the resident has impaired skin integrity as evidenced by stage III pressure ulcer to sacrum and an unstageable pressure to left gluteal fold. Interventions included low air loss mattress in place and pressure redistribution device in chair. Review of the resident's monthly physician orders for March 2026 identified orders dated 03/19/26 barrier cream after each incontinence episode, cleanse stage III pressure ulcer to sacrum with normal saline (NS), pat dry, apply triad paste and cover with foam dressing, cleanse unstageable pressure ulcer to left gluteal fold with normal saline, pat dry, apply triad past and leave open to air twice daily, 03/20/26 enhanced barrier precautions (EBP) due to wounds every shift, 03/24/26 low air loss mattress on bed for pressure reduction, monitor low air loss mattress functioning and check that the settings are appropriate for the resident every shift. On 03/24/26 at 12:51 P.M., an observation of Registered Nurse (RN) #237 provide the physician ordered wound care for Resident #157 revealed the RN provided the wound care to the resident's with the window blind open, facing another wing of the facility withing view of other resident's windows with open blinds. RN #287 verified privacy was not provided during wound care. Review of the facility policy titled, Resident Rights, dated 02/21 revealed federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right of privacy and confidentiality.		

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 04/07/2026
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)		
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 record review and staff interview, the facility failed to provide notice to the office of the state long-term care Ombudsman for resident transfers or discharges. This affected two (Residents #144 and #146) of three closed records reviewed. The facility census was 148. 1. Review of the closed record for Resident #146 revealed an admission date of 02/17/26 with diagnoses including alcoholic cirrhosis, peptic ulcer, hepatic encephalopathy, and protein/calorie malnutrition. The resident was at the facility for two days before being transferred to the hospital on [DATE]. The resident did not return to the facility. (The family requested the resident go to a different facility). Review of an email dated 03/03/26 at 5:48 P.M. from Human Resources Director #274 revealed it stated please find the February transfers and discharges notice from the facility. Resident #146's name was on the list. The email was sent to the State legal department. There was no evidence the State long-term care Ombudsman office was notified of the transfers or discharges. 2. Review of the closed record for Resident #144 revealed an admission date of 01/13/26 with diagnoses including diabetes, alcohol induced pancreatitis, malignant neoplasm of the glottis, congestive heart failure, and acute and chronic respiratory failure. Record review revealed the resident went out to a physician appointment on 01/30/26 and was sent to the hospital from the physician's office for further evaluation. The resident did not return to the facility. Hospital records revealed the resident remained in the hospital until 03/02/26 and was then transferred to another nursing facility. The facility provided a list of residents who were transferred or discharged in January 2026. Resident #144's name was on the list. There was no evidence the list was provided to the State long-term care Ombudsman. Interview with Human Resources Director #274 on 03/30/26 at 9:00 A.M. revealed she thought she was sending the monthly list of resident transfers/discharges to the State long-term care Ombudsman office but did not realize that the email address she was using was for the State legal department. She stated she had been emailing only the State legal department since at least August 2025.		

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 04/07/2026
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure resident assessments accurately reflected the number of pressure wounds present upon admission to the facility. This affected one (Resident #11) for wound care out of the 36 total sampled residents reviewed for accurate assessments. The facility census was 148. Findings include: Review of the medical record for Resident #11 revealed an admission date of 12/19/2025. Diagnoses included generalized anxiety, dementia, and wedge compression fracture of the thoracic vertebra. Review of Resident #11's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Per this assessment, Resident #11 was noted to have three stage III pressure ulcers (full-thickness skin loss forming a deep, crater-like wound where subcutaneous fat is visible, but muscle, tendons, or bone are not) where two of these three pressure ulcers were present upon admission to the facility. Review of a Skin Observation assessment dated [DATE] revealed Resident #11 had a pressure wound located on the coccyx measuring 5 centimeters (cm) in length by 7 cm in width and unable to determine the depth. Review of a Skin Observation assessment dated [DATE] revealed Resident #11 had a pressure wound to the coccyx which was present upon admission to the facility. Resident #11 was also noted with a pressure wound to the left heel measuring 3 cm in length by 3 cm in width by 0.1 cm in depth, which was not present upon admission to this facility. Resident #11 was also noted a pressure wound to the right heel measuring 3.5 cm in length by 3 cm in width by 0.1 cm in depth. This wound was also not noted to be present upon admission to the facility. Interview on 03/25/2026 at 9:37 A.M, with the Director of Nursing (DON) revealed when a new resident arrives to the facility, it is the responsibility of the floor nurse to complete nursing assessments which include whole body and skin assessments. This assessment is to be completed ASAP but at least within 24 hours post admission. The DON confirmed Resident #11 was admitted to the facility with one pressure wound to the coccyx and this resident's MDS assessment did not accurately reflect this when it indicated this resident had two pressure wounds upon admission, there was only one.		

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 04/07/2026
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)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure pre-admission screening and resident review (PASARR) was completed accurately for a resident. This affected one (#8) of five residents reviewed for PASARR. The facility census was 148. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction due to occlusion or stenosis of small artery, hypertension, and post-traumatic stress disorder (PTSD). Diagnoses of major depressive disorder and generalized anxiety were added 01/22/26 by the nurse practitioner. Review of the most recent PASARR documentation dated 01/26/26 revealed diagnoses of generalized anxiety and PTSD were not listed for Resident #8. Interview with Social Services Director #366 on 03/25/26 at 11:10 A.M. verified the PASARR dated 01/26/26 was missing additional diagnoses.		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure pre-admission screening and resident review (PASARR) was completed timely for a resident. This affected one (#8) of five residents reviewed for PASARR. The facility census was 148. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction due to occlusion or stenosis of small artery, hypertension and post-traumatic stress disorder (PTSD). Medical record review indicated Resident #8 had diagnosis of PTSD upon admission to facility. The PASARR was completed 10/31/25. Interview with Social Services Director #366 on 03/26/26 at 12:10 P.M. verified the PASARR dated 10/31/25 was not completed within 30-day timeframe from admission to the facility.		

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 04/07/2026
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)		
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review, observations, family interview, and staff interview, the facility failed to develop a baseline care plan that included the instructions needed to provide effective and person-centered care for each resident in the area of pain. This affected one (Resident #155) of four residents reviewed for pain. The facility census was 148. Review of the record for Resident #155 revealed an admission date of 03/17/26 and diagnoses including osteoporosis, chronic kidney disease, hypertension, depression, and anxiety disorder. A brief interview for mental status assessment conducted on 03/18/26 indicated a score of 15, intact cognition. Review of hospital records revealed the resident had a hospital stay from 03/03/26 to 03/17/26. The discharge summary stated the resident was admitted after a fall. She presented with a head hematoma, altered mental status, and left sided weakness. She was diagnosed with an acute traumatic subarachnoid hemorrhage enhanced by aspirin and an acute traumatic glenoid fracture (an injury to the shoulder socket). At the time of discharge to the facility she was afebrile, hemodynamically stable, breathing comfortably, eating a regular diet with oral pain medication, and tolerating therapies. Tylenol 1000 milligrams three times daily was ordered upon discharge. Review of physician's orders revealed an order on 03/17/26 to monitor pain every shift and record pain number on a 0-10 scale. The resident started receiving Tylenol 1000 milligrams three times daily on 03/18/26 at 8:00 A.M. Review of nursing progress notes on 03/19/26 at 12:36 P.M. revealed the resident was found laying on the floor in her room. Alert and oriented x 2. Denied pain. Resident reports mild pain to left shoulder. A left shoulder x-ray was ordered. Review of a progress note by the nurse practitioner on 03/19/26 revealed a fall on this day of visit. Shoulder x-ray reviewed and non-acute. On 03/19/26 a lidocaine patch was ordered daily as needed. (a topical patch to relieve pain). Review of a progress note by the nurse practitioner on 03/20/26 revealed resident reported pain at 5/10 but managed well. (Only Tylenol given. No Lidocaine patches documented as given). Interview with Resident #155's daughter on 03/23/26 at 1:51 P.M. revealed that she felt that after the fall on 03/19/26 the resident was sleeping more, more confused, more delirium towards evening. She stated the resident was not like that at the hospital. She felt she had slowly gotten worse since the fall at the facility 03/19/26. She stated she stays until late evening because she is afraid the resident is going to get up by herself and fall again. She stays until she is asleep. She further stated she did not feel the facility was managing the residents chronic back pain. She stated the resident took Tylenol at home but was having more pain now. During the interview, Resident #155 was in bed and kept fidgeting around in the bed and acted as if she was uncomfortable. Observations on 03/24/26 at 8:28 A.M. revealed the nursing assistant to deliver the residents breakfast tray to the room. The resident was flat in bed. The nursing assistant asked the resident if she wanted to eat and she responded no. The resident was complaining of back pain and was left flat in the bed. The nursing assistant said she would leave the tray in case the resident got hungry. The resident remained in bed with her eyes closed. Observations on 03/24/26 at 10:03 A.M. revealed the resident's son was visiting. The resident was up in a recliner in the room. He stated he felt the resident's cognition had declined since being at the facility. The resident was observed to be moaning out in pain. She was stating that the pain was in her upper back. He stated that she is not usually like this and this pain level is not consistent with what she has had prior. He stated for the last two days she just wants to lay in bed. (The resident's yelling and moaning out in pain could be heard in the hallway). No staff responded. On 03/24/26 at 10:14 A.M. the surveyor summoned the unit nurse (LPN #404) and Corporate Nurse #401 to come to the room due to the resident repeatedly yelling out in pain over and over again. The resident continued to yell out in pain when they entered the room. Interview with LPN #404 on 03/24/26 at 10:16 A.M. revealed she was an agency nurse and this was the first time she had ever worked on that hallway. She confirmed that Resident #155 had been hollering out in pain this morning and she gave her the scheduled Tylenol (continued on next page)		

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 04/07/2026
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)		
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	around 8:50 A.M. She stated she went back to the room around 9:30 A.M. and the resident was still in pain so they got her up in the recliner. She stated she had not been back to assess the resident since around 9:30 A.M. Observations on 03/24/26 at 10:20 A.M. revealed the nurse practitioner to enter Resident #155's room. He stayed in the room approximately 3-5 minutes. Review of the nurse practitioner note on 03/24/26 revealed in obvious discomfort on exam. Reports neck, low back, and sacral pain. Uncontrolled with conservative treatments. (Review of medication administration record revealed the Lidocaine patch ordered on 03/19/26 was never documented as being administered prior to 03/24/26). Review of a nursing progress note on 03/24/26 at 10:30 A.M. revealed resident noted to be sitting up in reclining chair yelling out. This nurse assessed resident. Resident stated she had pain in spine. Floor nurse stated resident was given Tylenol around 8:30 A.M. Resident voiced lying flat helps with the pain. Resident transferred to bed and repositioned. Nurse practitioner in house and assessed resident at bedside. New orders received. The next nursing progress note on 03/24/26 at 10:35 A.M. stated Oxycodone 2.5 milligrams (narcotic pain medication) was ordered due to an increase in pain to left shoulder, neck, and mid back that was unrelieved with non-pharmacological interventions. None of the progress notes indicated the residents level of pain on a scale of 0-10. Observations on 03/24/26 at 10:32 A.M. revealed the resident to be in bed. The resident was moaning out repeatedly in pain. Her son asked her what month it was and she said April, then July (it was March). He asked her what day it was and she said Thursday (it was Tuesday). Observations on 03/24/26 at 10:37 A.M. revealed the resident to still be moaning out repeatedly in pain. Review of the medication administration record revealed the Oxycodone pain medication ordered by the nurse practitioner was given on 03/24/26 at 10:46 A.M. Review of a nursing progress note on 03/24/26 at 10:46 A.M. revealed the Oxycodone was given due to complaints of pain and resident is calling out. The nurse attempted to resolve pain with Tylenol (given around 8:30 A.M. per previous note) and attempt was unsuccessful. Observations on 03/24/26 at 11:10 A.M. revealed the resident to be in bed, moaning repeatedly and saying help. (no staff in room). Observations on 03/24/26 at 11:13 A.M. revealed Nursing Assistant #246 to be walking down the hall with another resident towards the shower room. She stated she was the only aide on the hall. She walked by Resident #155's room where the resident could be heard in the hallway moaning and yelling out. Nursing assistant #246 walked on by the room and went into the shower room with the other resident. (There was no other staff in Resident #155's room). Observations on 03/24/26 at 11:15 A.M. revealed Registered Nurse (RN) #500 to enter the resident's room. The resident was still complaining of pain. RN #500 said she would get the resident a Lidocaine patch. Review of a nursing progress note on 03/24/26 at 11:16 A.M. revealed the resident reported pain at 4 out of 10. The note indicated the medication was effective. Observations on 03/24/26 at 11:18 A.M. revealed Director of Therapy Services #336 enter the room. The resident was in bed. Director of Therapy Services #336 asked the resident if she wanted to sit in a chair, even though she had just been placed in bed at 10:30 A.M. due to pain while up in the chair. Observations on 03/24/26 at 11:20 A.M. revealed a Lidocaine patch was applied to the residents shoulder. Review of a nursing progress note on 03/24/26 at 11:20 A.M. revealed the nurse assessed resident after administering pain medication. Resident reported pain level 4 out of 10 after receiving. Nurse to put lidocaine patch on resident per her request. Although resident says pain medication was effective, she still continues to yell out. Review of a nursing progress note on 03/24/26 at 11:29 A.M. revealed the resident had a change in condition of pain (uncontrolled). An order was received to send the resident to the hospital for evaluation. Review of a change in condition evaluation form for 03/24/26 at 11:29 A.M. completed by Licensed Practical Nurse (LPN) #223 revealed the resident had acute, uncontrolled pain of the back. It stated the resident was not cognitively able to rate pain scale. It stated the pain started on the night of 03/23/26. It stated she had memory loss-new or worsening, an abrupt decline in memory or mental status without other apparent symptoms and needs more assistance with activities of daily living including ambulation, bathing, bowel and bladder management, dressing, and transferring. Observations on 03/24/26 at (continued on next page)		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:50 A.M. revealed emergency personnel entering Resident #155's room to transfer her to the hospital. The resident did not have a plan of care for pain. This was confirmed by the Director of Nursing on 03/30/26 at 8:25 A.M.		

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/07/2026
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)		
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 and staff interview, the facility failed to develop and implement a person-centered comprehensive care plan. This affected one (#8) of 36 residents reviewed for care planning. The facility census was 148. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction due to occlusion or stenosis of small artery, hypertension, and post-traumatic stress disorder (PTSD). Diagnoses of major depressive disorder and generalized anxiety were added 01/22/26 by the nurse practitioner. Medical record review of the most recent Minimum Data Set (MDS) assessment dated [DATE] validated diagnoses of major depressive disorder, generalized anxiety and PTSD. Recent care plan dated 03/11/26 revealed anxiety, depression and PTSD were not addressed in plan of care. Interview with Social Services Director #366 on 03/26/26 at 12:10 P.M. verified the care plan did not address anxiety, depression and PTSD for Resident #8.		

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 04/07/2026
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, resident interview, and staff interview, the facility failed to develop a comprehensive care plan for a resident in the area of constipation. This affected one (Resident #78) of 36 residents whose care plans were reviewed. The facility census was 148. Review of the record for Resident #78 revealed an admission date of 08/08/22 with diagnoses including constipation (dated 02/15/22), diabetes, convulsions, panic disorder, and chronic kidney disease. Interview with Resident #78 on 03/24/26 at 9:14 A.M. revealed that she has a problem with constipation. She stated she thinks it is due to the narcotic pain pills she takes for her back pain. She stated the pain medication is taken as needed but she usually asks for and takes it twice daily. She stated she has been taking different medications for her constipation but they were not working so the nurse practitioner just ordered a new medication to take. She stated she had x-rays to check her bowels about a month ago. She stated she sometimes has to digitally remove her stool as it won't come out. Review of physician's orders revealed the resident had eleven current orders for laxatives/medications for constipation as follows: 03/24/26 Linzess 290 micrograms daily for constipation; 03/19/26 Miralax packet every six hours as needed for constipation (was being given routinely from 10/24/25 until 03/19/26); Senna 8.6 milligrams (mg) every six hours as needed for constipation (was being given twice daily from 06/04/25 until 03/19/26); Lactulose 10 grams/15 milliliters- give 30 milliliters every six hours as needed for constipation (was being given twice daily from 02/19/26 until 03/19/26); 03/06/26 Milk of magnesia 30 milliliters every 24 hours as needed for constipation. If no results in 12 hours follow bowel protocol; 03/06/26 Dulcolax suppository 10 mg rectally as needed if no results from milk of magnesia; 03/06/26 fleets enema as needed for no bowel movement after suppository for constipation. If no results in six hours, call physician; 02/21/26 Fibercon tablet 625 mg twice daily for constipation; 11/06/25 Docusate Sodium 100 mg twice daily for constipation; 06/03/25 Docusate Sodium 100 mg daily as needed for constipation; 06/03/25 Bisacodyl 5 mg as needed for constipation. Review of the annual Minimum Data Set assessment 07/22/25 revealed the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition. It stated the resident took scheduled and as needed pain medications. Review of nursing progress notes dated 01/31/26 at 12:03 P.M. revealed the resident approached nurse and asked to have stool examined. Still in toilet. Saw blood on side of toilet. Blood tinged water and clots laying with stool in toilet. Resident stated was having bowel movement but could feel a large amount stuck that would not move. Resident said she manually removed stool. Nurse Practitioner contacted. On 02/02/26 at 2:12 P.M. the nurse documented that the resident was educated not to manually remove stool and to notify staff when experiencing difficulty with bowel movements so stool softeners or other interventions could be provided. Resident stated this was not the first occurrence of manual stool removal. On 02/05/26 an abdominal x-ray was completed due to history of stool burden. Results large bowel loops with moderate fecal load suggestive of constipation. On 02/19/26 at 5:36 P.M. nursing progress notes indicated the resident was seen by the nurse practitioner due to constipation and abdominal pain/distention. New orders were received for lab work and medication. On 03/05/26 at 5:36 P.M. nursing progress notes indicated the resident had abdominal pain, constipation, or impaction. A new order for an x-ray was obtained. On 03/06/26 an abdominal x-ray was completed due to history of constipation. The large bowel demonstrates prominent fecal loading, compatible with constipation. On 03/06/26 at 5:55 P.M. nursing progress noted indicated a new order was received to initiate bowel protocol. The medication administration record documented that milk of magnesia was given and was effective on 03/06/26. Review of the plan of care for Resident #78 revealed it did not include a plan for constipation or any interventions related to constipation. Interview with Corporate Clinical Nurse #400 on 03/26/26 at 3:15 P.M. confirmed Resident #79's plan of care did not address constipation.		

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 04/07/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for 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** Based on interview, record review and review of facility policy, the facility failed to provide blood pressure medication as needed according to the physician ordered parameters. This affected one resident (#7) of five sampled for unnecessary medications. The facility census was 148. Findings include: Review of Resident #7's medical record revealed an admission date of 05/30/25, a re-entry date of 02/11/26 and diagnoses including cerebral infarction, anxiety disorder, chronic kidney disease stage four, major depressive disorder, diabetes, dementia, unspecified protein-calorie malnutrition, and abdominal aortic aneurysm without rupture. Review of Resident #7's admission minimum data set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. Review of Resident #7's physician's orders revealed an order dated 02/11/26 for clonidine 0.2 milligrams (MG) give one tablet by mouth every six hours as needed for hypertension. Give if blood pressure is greater than 140. Review of Resident #7's Medication Administration Record (MAR) revealed the resident had not received the clonidine medication in March 2026. Further review of the MAR revealed the resident's blood pressure was being checked twice daily and on 03/02/26 at 8:00 A.M. the resident's blood pressure was 148/89, on 03/06/26 at 8:00 A.M. the resident's blood pressure was 146/88, on 03/11/26 at 8:00 P.M. the resident's blood pressure was 147/88, on 03/12/26 at 8:00 P.M. the resident's blood pressure was 150/81, on 03/21/26 at 8:00 P.M. the resident's blood pressure was 149/78, and on 03/23/26 at 8:00 P.M. the resident's blood pressure was 149/87. In an interview on 03/26/26 at 3:45 P.M. Licensed Practical Nurse (LPN) #348 confirmed the MAR indicated Resident #7 had not received the medication clonidine in the month of March and confirmed the resident's blood pressure results on 03/02/26 at 8:00 A.M. of 148/89, on 03/06/26 at 8:00 A.M. of 146/88, on 03/11/26 at 8:00 P.M. of 147/88, on 03/12/26 at 8:00 P.M. of 150/81, on 03/21/26 at 8:00 P.M. of 149/78, and on 03/23/26 at 8:00 P.M. of 149/87 indicated the medication should have been given. Review of the policy titled Administering Medication, revised December 2012, revealed medications are to be administered in accordance with physicians orders.		

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 04/07/2026
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)		
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 observation, medical record review, interview and facility policy review, the facility failed to ensure indwelling urinary catheter collection bags were positioned below the bladder. This affected one resident (#108) of two residents reviewed for catheters. The facility census was 148. Findings Include: Review of the medical record for Resident #108 revealed an initial admission date of 08/23/23 with the latest readmission date of 03/02/26 with the diagnoses including but not limited to chronic kidney disease, , paraplegia, retention of urine, diabetes mellitus, mild intellectual disabilities, chronic pain, end stage renal disease, paranoid schizophrenia, major depressive disorder, benign prostatic hyperplasia, bladder neck obstruction, obstructive and reflux uropathy, kidney transplant status, spinal stenosis, need for assistance with personal care and chronic obstructive pulmonary disease. Review of the plan of care dated 12/18/24 revealed the resident had an indwelling suprapubic catheter size 16 French. Interventions included monitor and document intake and output as per facility policy. Review of the plan of care dated 11/30/23 revealed the resident had urinary retention secondary to obstructive uropathy. Interventions included catheter per physician orders, monitor intake and output, observe and report signs of retention, provide catheter care every shift and report redness or drainage as appropriate. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident was dependent for toileting. The assessment indicated the resident had an indwelling urinary catheter and was always incontinent of bowel. Review of the resident's monthly physician orders for March 2026 identified orders dated 03/02/26 maintain suprapubic catheter size 16 French with 10 milliliter (ml) balloon for bladder neck obstruction, change suprapubic catheter size 16 French with 10 ml balloon as needed, catheter care every shift, may irrigate catheter with 60 ml sterile water as needed for blockage, change catheter collection bag every 30 days and or if bag is visibly soiled. On 03/24/26 at 9:10 A.M., observation of Resident #108 revealed his indwelling urinary catheter collection bag was hanging above his bladder on his left enabler bar on his bed. On 03/24/26 at 9:15 A.M., an interview with Registered Nurse (RN) #415 verified the resident's indwelling urinary catheter collection bag was hanging above his bladder posing the potential of urine to backflow back into the bladder. Review of the facility policy titled, Urinary Catheter Care, dated 02/24 revealed the purpose of the policy was to prevent catheter associated urinary tract infections. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.		

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 04/07/2026
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)		
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 medical record review, staff interview, observations, and facility policy review, the facility failed to address significant weight loss. This affected three residents (Resident #17, #29, #90) of the 6 residents reviewed for an adequate nutritional status. The facility census was 148. Findings include: 1 Review of the medical record for Resident #90 revealed an admission date of 03/29/2023. Diagnosis included Alzheimer's disease, diverticulosis of the large intestines, and abnormal weight loss. Review of the plan of care dated 09/17/2024 revealed Resident #90 had nutritional problem or potential nutritional problem related to the diagnosis of Alzheimer's dementia, diverticulosis, prostate cancer, dysphagia, diet, mechanically altered, edentulous, variable intake, prefers almond milk. Interventions include to assist residents with meals as needed, encourage fluid intakes, provide supplements as ordered, provide diet as ordered, monitor intake and record every meal, Registered Dietitian to evaluate and make diet changes and to obtain weights as ordered. Review of Resident #90's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Resident #90 was noted to be independent for eating and was 73 inches tall and weighted 183 pounds. Review of Resident #90's weights revealed on 02/18/2026 this resident weighted 187.1 pounds obtained via the facility's therapy scale. On 03/22/2026, Resident #90 weighted 170.8 pounds obtained via the wheelchair scale. This indicated a 16.3-pound weight loss in a month. No evidence of a re-weigh being completed was noted. Interview on 03/30/2026 at 2:00 P.M. with the Director of Nursing (DON) confirmed there was a weight loss documented for Resident #90 with no re-weight or evidence of the Dietitian being notified of this weight loss. A re-weight should have been completed at the time of the weight change being noted. Interview on 03/30/2026 at 3:00 P.M. with Registered Dietitian (RD) #200 confirmed she had not been informed Resident #90 had a documented weight loss. 2. Review of the record for Resident #29 revealed an admission date of 02/09/26 and diagnoses including vascular dementia, cerebral infarction, viral hepatitis C, and substance dependence. Review of a progress note by the nurse practitioner on 02/10/26 at 10:19 P.M. revealed the resident was a homeless male with chronic hepatitis C, polysubstance abuse disorder, and left middle cerebral artery stroke with residual severe expressive aphasia (impairment to the ability to communicate that affects speech, writing, and understanding language). A nursing progress note on 02/11/26 at 2:55 P.M. revealed staff were reporting the resident was refusing meals, only drinking coffee. Had some pizza and soda in therapy gym today. Physician notified of refusals. Review of a nutritional risk assessment completed 02/11/26 revealed Resident #29 was on a regular (continued on next page)		

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 04/07/2026
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diet. Hospital weight noted to be 222 pounds. Height and weight on admission [DATE] noted to be 73 inches and 220.8 pounds. His body mass index (BMI) was 29.1. His percentage of meals eaten were noted to be 50-75% and 75-100%. Intake appears adequate. At risk for malnutrition related to BMI greater than 25 and chronic disease. Will follow. Review of the admission Minimum Data Set assessment completed 02/15/26 revealed a Brief Interview for Mental Status score of 00, indicating severe cognitive impairment. He was noted to be set up help only for eating and independent with mobility. No weight loss or gain was noted. On 02/16/26 his weight was noted to be 209 pounds. This represented a 11.8 pound, 5.3 % severe weight loss in one week. There was no evidence the resident was re-weighed to determine if the weight was accurate until 02/23/26. A dietary progress note on 02/17/26 noted the resident had a 5.3%, 11.8 pound significant weight loss x 30 days. Has had decreased intakes since admission which may have contributed to weight loss. Noted diagnosis of vascular dementia. Disease process may contribute to weight change. Recommend Boost 237 milliliters (ml) twice daily. A physician's order was obtained for Boost 237 ml twice daily on 02/20/26. A weight completed on 02/23/26 indicated the resident weighed 207.8 pounds. This represented an additional 1.2 pound weight loss in one week. The next weight on 03/10/26 was 205.2 pounds. This represented an additional 2.6 pound weight loss in 2 weeks. The resident had lost a total of 15.6 pounds in one month. This represented a 7% severe weight loss in one month. Review of a dietary progress note on 03/10/26 revealed the resident had experienced a 15.6 pound, 7.1% significant weight loss in 30 days. Intakes show most intake 75-100%. No change in nutrition prescription at this time. Will follow. On 03/14/26 a physician's order was obtained to increase Mirtazepine (an antidepressant which can help with appetite stimulation) from 7.5 milligrams to 15 milligrams daily. Observations on 03/25/26 at 7:49 A.M. revealed Resident #29's breakfast tray to be taken to his room. He received four pancakes, a bowl of cream of wheat, apple juice, and milk. He asked for coffee and told the nursing assistant that all he wanted for breakfast was coffee. She obtained a cup of coffee for him. On 03/25/26 at 8:06 A.M. he had eaten one pancake and drank his milk. He stated he did not want anymore and was drinking his coffee. Observations on 03/25/26 at 11:53 A.M. revealed his lunch tray was delivered to his room. He received a hamburger, potatoes, peas and carrots, two containers of grape juice, and a slice of boston cream pie. On 03/25/26 at 12:08 pm he had eaten the potatoes and peas/carrots. He did not eat the hamburger, juice, or boston cream pie. Interview with Nursing Assistant #249 on 03/25/26 at 2:36 P.M. (served breakfast and lunch to Resident #29 that day) revealed that she had worked at the facility 5-6 months. She stated she normally worked dayshift. She stated she was not aware of Resident #29 having any weight loss. She stated that he ate one pancake for breakfast and ate his vegetables and pie for lunch. She stated she had not documented his meal intake yet. (continued on next page)		

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 04/07/2026
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/26/26 review of meal intake records for 03/25/26 revealed there were no meal intakes recorded for that day. On 03/26/26 it was documented that he ate 0-25% of breakfast on 03/26/26. Interview with the Director of Nursing on 03/26/26 at 2:20 P.M. confirmed there were no meal intakes documented for 03/25/26 for Resident #29. She stated that intakes for each meal should be documented. There was no evidence Resident #29 had been weighed again since 03/10/26. (when it was identified that he had experienced a 15.6 pound, 7.1% severe weight loss in one month). Review of the plan of care dated 02/11/26 revealed Resident #29 had a nutritional problem or potential nutritional problem related to atrial fib, chronic viral hepatitis C, vascular dementia, anemia, aphasia, psychoactive substance abuse, and cerebral infarctions. The goal was to maintain adequate nutritional status as evidenced by maintaining weight with no unplanned significant weight change through next review. Interventions included monitor/record/report to physician as needed for signs/symptoms of malnutrition: emaciation, muscle wasting, significant weight loss: 3 pounds in 1 week, greater than five percent in one month, greater than 7.5 percent in three months, greater than 10 percent in six months. However, the plan of care did not specify how often the resident was to be weighed. Interview with Dietician #200 on 03/25/26 at 2:01 P.M. confirmed that the last weight entered into the medical record for Resident #29 was on 03/10/26. She stated there was no timeline for re-weighing residents after a significant weight change. She stated the facility policy did not address how frequently to weigh residents. She stated the policy was up to the company. She stated she could not answer about how often a resident should be weighed when experiencing significant weight loss. She stated the interdisciplinary team decided how often to weigh residents. When asked if she was part of the interdisciplinary team, she responded that she was but was not able to attend the interdisciplinary team meeting so she does not know how often Resident #29 should be weighed due to continued weight loss. Interview with Corporate Registered Nurse #401 on 03/25/26 at 2:15 P.M. confirmed Resident #29 had no further weights documented after 03/10/26. She stated the resident had no physician's orders on how often to be weighed. She confirmed the plan of care did not address how often to weigh the resident. Interview with Corporate Clinical Nurse #400 on 03/25/26 at 2:15 P.M. revealed the dietician should recommend how often to weigh residents when there is a significant weight loss. Interview with Director of Therapy Services #336 on 03/25/26 at 4:15 P.M. revealed she had weighed Resident #29 on 03/17/26 at the request of someone in nursing (did not know who). She stated he weighed 206.8 pounds on that date but she did not document it as she can't document weights. Observations on 03/26/26 at 11:30 A.M. revealed Director of Therapy Services #336 to weigh Resident #29 twice. Both times her weighed 219.8 pounds. 3. Review of the medical record for Resident #17 revealed an initial admission date of 11/10/21 with the latest readmission date of 11/13/24 with the diagnoses including but not limited to atrial fibrillation, benign prostatic hyperplasia with lower urinary tract symptoms, dementia with anxiety, mood disturbance, chronic pain syndrome, dysphagia, retention of urines, chronic sinusitis, (continued on next page)		

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 04/07/2026
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension, chronic kidney disease, rheumatic mitral stenosis, gastro-esophageal reflux disease (GERD), gout, Barrett's esophagus and major depressive disorder. Review of the plan of care dated 09/09/24 revealed the resident had a nutritional problem or potential nutritional problem. Interventions included monitor/document/report to physician as needed for signs/symptoms of dysphagia, monitor/record/report to physician as needed any signs/symptoms of malnutrition, emaciation, muscle wasting, significant weight loss of three pounds in one week, great than 5% in one month, greater than 7.5% in three months and greater than 10% in six months, (RD) to evaluate and make diet change recommendations as needed and weights as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident had indicators of depression and displayed no behaviors. The resident required set-up or clean up assistance with meals. The assessment indicated the resident was 142 pounds and had no known weight loss. Review of the resident's weights revealed on 03/02/26 the resident weighed 127.2 pounds, 02/03/26 the resident weighed 141.8 pounds indicating the resident had lost 14.6 pounds or 10.3% of his body weight in the past 30 days. Review of the individual nutrition recommendations/response dated 03/03/26 revealed the RD notified the physician of the 14.6 pounds or 10.3% weight loss in 30 days. The recommendation was to reweigh to assess if weight was accurate. The physician addressed the recommendation and agreed to the recommendation on 03/05/26. Review of the dietary progress note dated 03/03/26 at 2:42 P.M. revealed a weight loss warning of 10.3% or 14.6 pound weight loss in 30 days. The Dietician recommended a reweight for accuracy. The Dietician made no recommendations and would follow-up with reweight. Review of the medical record revealed no reweight was obtained for the resident and the RD had made no follow up on the lack of the reweight. Review of the resident's monthly physician orders for March 2026 identified orders dated 11/14/24 regular diet, 02/10/25 Healthshake (nutritional supplement) four ounces with lunch and supper. On 03/25/26 at 12:22 P.M., observation of the resident's lunch meal tray revealed no Healthshake on the tray. Review of the resident's meal ticket revealed the resident was to receive a Healthshake with the meal. On 03/25/26 at 12:32 P.M., an interview with Certified Nursing Assistant (CNA) #306 verified the resident had not received a Healthshake on his lunch meal tray as physician ordered. On 03/25/26 at 1:30 P.M., an interview Registered Dietitian (RD) #200 revealed the resident was weighed on a new scale and he did not appear the stated weight. On 03/25/26 at 1:57 P.M., observation of the resident's reweight revealed the resident weighed 132.7 pounds. Interview with the RD at the time of the observation revealed when asked if she was provided with a reweight revealed she said the reweight is provided when placed in the electronic medical record. She said the policy had no timeline to obtain a reweight. She stated, All I can tell you is there (continued on next page)		

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 04/07/2026
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is no timeline per the policy, when asked if she would expect the reweight to be done sooner. Review of the job description for the dietician signed by Dietician #200 on 01/19/24 revealed the dietician assists the facility in the overall responsibility for the operation of medical nutrition therapies and food service operations to comply with all local, state, federal, and joint commission regulations as applicable to the setting. The dietician assists in writing/editing policies/procedures for overall guidance to the facility. The dietician is responsible for clinical nutritional documentation and medical nutrition therapy using the nutrition care process to assess each individual's nutrition status, diagnoses nutrition conditions, assists in the selection of appropriate nutrition interventions, monitors/evaluates progress, and provided nutrition education as needed. Review of the facility policy dated 2001 and revised September 2024 titled Weight Assessment and Intervention revealed the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff will measure resident weights on admission and readmission. Additional weights will be obtained at the discretion of the facility. Weights will be recorded in each resident clinical record. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will immediately notify the dietician. The dietician will review the resident weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month-5% weight loss is significant; greater than 5% is severe. 6 months-10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort. Individualized care plans shall address, to the extent possible, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment.		

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 04/07/2026
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)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure a physician or practitioner order for supplemental oxygen was in place for a resident that used it continuously. This affected one (Resident #4) of three residents reviewed for respiratory care. The facility census was 148 residents. Findings include: Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] and readmitted [DATE]. Resident #4 had diagnoses that included other specified chronic obstructive pulmonary disease, unspecified open wound of unspecified front wall of thorax without penetration into thoracic cavity, chronic obstructive pulmonary disease with (acute) exacerbation, personal history of pulmonary embolism, pleural effusion, emphysema, shortness of breath, acute and chronic respiratory failure unspecified whether with hypoxia or hypercapnia, and obstructive sleep apnea. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact. Resident did not wear oxygen therapy. Review of Resident #4's orders on 03/25/26 at 1:00 P.M. revealed a discontinued order for oxygen via nasal cannula at 4-5 L to maintain saturation above 90% discontinued 01/13/26. Further review of Resident #4's active orders did not reveal an active order for supplemental oxygen. Observation of Resident #4 on 03/25/2026 at 2:03 P.M. revealed the resident was wearing oxygen at three liters via nasal cannula. Interview with Resident #4 on 03/25/2026 at 2:03 P.M. revealed the resident required oxygen at three liters via nasal cannula continuously. Observation of Resident #4 on 03/26/2026 at 8:09 A.M. revealed the resident was wearing oxygen at three liters via nasal cannula. Interview with Licensed Practical Nurse (LPN) #348 on 03/26/26 at 8:34 A.M. confirmed a physician or practitioner order was not in place for Resident #4. Further interview with LPN #348 revealed Resident #4 requires oxygen continuously and should have an order in place. Review of policy 'Oxygen Administration' dated July 2024 revealed preparation for safe oxygen administration included verifying that there is a physician's order for the procedure.		

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 04/07/2026
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)		
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 observations, family interview, staff interview, record review, and policy review, the facility failed to recognize, evaluate, and manage acute pain for a resident. This affected one (Resident #155) of four residents reviewed for pain. The facility census was 148. Review of the record for Resident #155 revealed an admission date of 03/17/26 and diagnoses including osteoporosis, chronic kidney disease, hypertension, depression, and anxiety disorder. Review of hospital records revealed the resident had a hospital stay from 03/03/26 to 03/17/26. The discharge summary stated the resident was admitted after a fall. She presented with a head hematoma, altered mental status, and left sided weakness. She was diagnosed with an acute traumatic subarachnoid hemorrhage enhanced by aspirin and an acute traumatic glenoid fracture (an injury to the shoulder socket). At the time of discharge to the facility she was afebrile, hemodynamically stable, breathing comfortably, eating a regular diet with oral pain medication, and tolerating therapies. Tylenol 1000 milligrams three times daily was ordered upon discharge. A brief interview for mental status assessment conducted on 03/18/26 indicated a score of 15 out of 15, intact cognition. Review of physician's orders revealed an order on 03/17/26 to monitor pain every shift and record pain number on a 0-10 scale. The resident started receiving Tylenol 1000 milligrams three times daily on 03/18/26 at 8:00 A.M. Review of history and physical by the physician on 03/18/26 revealed the resident had mild confusion and no pain. Review of nursing progress notes on 03/19/26 at 12:36 P.M. revealed the resident was found laying on the floor in her room. Alert and oriented x 2. Denied pain. Resident reports mild pain to left shoulder. A left shoulder X-ray was ordered. Review of a progress note by the nurse practitioner on 03/19/26 revealed a fall on this day of visit. Shoulder X-ray reviewed and non-acute. On 03/19/26 a lidocaine patch was ordered daily as needed. (a topical patch to relieve pain). Review of a progress note by the nurse practitioner on 03/20/26 revealed resident reported pain at 5/10 but managed well. (Only Tylenol given. No Lidocaine patches documented as given). Interview with Resident #155's daughter on 03/23/26 at 1:51 P.M. revealed that she felt that after the fall on 03/19/26 the resident was sleeping more, more confused, more delirium towards evening. She stated the resident was not like that at the hospital. She felt she had slowly gotten worse since the fall at the facility 03/19/26. She stated she stays until late evening because she is afraid the resident is going to get up by herself and fall again. She stays until she is asleep. She further stated she did not feel the facility was managing the residents chronic back pain. She stated the resident took Tylenol at home but was having more pain now. During the interview, Resident #155 was in bed and kept fidgeting around in the bed and acted as if she was uncomfortable. Review of the medication administration record revealed the every shift pain monitoring records documented 0 pain from 03/18/26-03/23/26. The resident did not have a plan of care for pain. This was confirmed by the Director of Nursing on 03/30/26 at 8:25 A.M. Observations on 03/24/26 at 8:28 A.M. revealed the nursing assistant to deliver the residents breakfast tray to the room. The resident was flat in bed. The nursing assistant asked the resident if she wanted to eat and she responded no. The resident was complaining of back pain and was left flat in the bed. The nursing assistant said she would leave the tray in case the resident got hungry. The resident remained in bed with her eyes closed. Observations on 03/24/26 at 10:03 A.M. revealed the resident's son was visiting. The resident was up in a recliner in the room. He stated he felt the resident's cognition had declined since being at the facility. The resident was observed to be moaning out in pain. She was stating that the pain was in her upper back. He stated that she is not usually like this and this pain level is not consistent with what she has had prior. He stated for the last two days she just wants to lay in bed. (The resident's yelling and moaning out in pain could be heard in the hallway). No staff responded. On 03/24/26 at 10:14 A.M. the surveyor summoned the unit nurse (LPN #404) and Corporate Nurse #401 to come to the room due to the resident repeatedly yelling out in pain over and over again. The resident continued to yell out in pain when they entered the room. Interview (continued on next page)		

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 04/07/2026
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with LPN #404 on 03/24/26 at 10:16 A.M. revealed she was an agency nurse and this was the first time she had ever worked on that hallway. She confirmed that Resident #155 had been hollering out in pain this morning and she gave her the scheduled Tylenol around 8:50 A.M. She stated she went back to the room around 9:30 A.M. and the resident was still in pain so they got her up in the recliner. She stated she had not been back to assess the resident since around 9:30 A.M. Observations on 03/24/26 at 10:20 A.M. revealed the nurse practitioner to enter Resident #155's room. He stayed in the room approximately 3-5 minutes. There were no nursing progress notes between 03/22/26 and 03/24/26. Review of the nurse practitioner note on 03/24/26 revealed in obvious discomfort on exam. Reports neck, low back, and sacral pain. Uncontrolled with conservative treatments. (Review of medication administration record revealed the Lidocaine patch ordered on 03/19/26 was never documented as being administered prior to 03/24/26). Review of a nursing progress note on 03/24/26 at 10:30 A.M. revealed resident noted to be sitting up in reclining chair yelling out. This nurse assessed resident. Resident stated she had pain in spine. Floor nurse stated resident was given Tylenol around 8:30 A.M. Resident voiced lying flat helps with the pain. Resident transferred to bed and repositioned. Nurse practitioner in house and assessed resident at bedside. New orders received. The next nursing progress note on 03/24/26 at 10:35 A.M. stated Oxycodone 2.5 milligrams (narcotic pain medication) was ordered due to an increase in pain to left shoulder, neck, and mid back that was unrelieved with non-pharmacological interventions. None of the progress notes indicated the residents level of pain on a scale of 0-10. Observations on 03/24/26 at 10:32 A.M. revealed the resident to be in bed. The resident was moaning out repeatedly in pain. Her son asked her what month it was and she said April, then July (it was March). He asked her what day it was and she said Thursday (it was Tuesday). Observations on 03/24/26 at 10:37 A.M. revealed the resident to still be moaning out repeatedly in pain. Review of the medication administration record revealed the Oxycodone pain medication ordered by the nurse practitioner was given on 03/24/26 at 10:46 A.M. Review of a nursing progress note on 03/24/26 at 10:46 A.M. revealed the Oxycodone was given due to complaints of pain and resident is calling out. The nurse attempted to resolve pain with Tylenol (given around 8:30 A.M. per previous note) and attempt was unsuccessful. Observations on 03/24/26 at 11:10 A.M. revealed the resident to be in bed, moaning repeatedly and saying help. (no staff in room). Observations on 03/24/26 at 11:13 A.M. revealed Nursing Assistant #246 to be walking down the hall with another resident towards the shower room. She stated she was the only aide on the hall. She walked by Resident #155's room where the resident could be heard in the hallway moaning and yelling out. Nursing assistant #246 walked on by the room and went into the shower room with the other resident. (There was no other staff in Resident #155's room). Observations on 03/24/26 at 11:15 A.M. revealed Registered Nurse (RN) #500 to enter the resident's room. The resident was still complaining of pain. RN #500 said she would get the resident a Lidocaine patch. Review of a nursing progress note on 03/24/26 at 11:16 A.M. revealed the resident reported pain at 4 out of 10. The note indicated the medication was effective. Observations on 03/24/26 at 11:18 A.M. revealed Director of Therapy Services #336 enter the room. The resident was in bed. Director of Therapy Services #336 asked the resident if she wanted to sit in a chair, even though she had just been placed in bed at 10:30 A.M. due to pain while up in the chair. Observations on 03/24/26 at 11:20 A.M. revealed a Lidocaine patch was applied to the residents shoulder. Review of a nursing progress note on 03/24/26 at 11:20 A.M. revealed the nurse assessed resident after administering pain medication. Resident reported pain level 4 out of 10 after receiving. Nurse to put lidocaine patch on resident per her request. Although resident says pain medication was effective, she still continues to yell out. Review of the medication administration record revealed there was no documentation to indicate the Lidocaine patch was applied. Review of a nursing progress note on 03/24/26 at 11:29 A.M. revealed the resident had a change in condition of pain (uncontrolled). An order was received to send the resident to the hospital for evaluation. Review of a change in condition evaluation form for 03/24/26 at 11:29 A.M. completed by Licensed Practical Nurse (LPN) #223 revealed the resident had acute, uncontrolled pain of the (continued on next page)		

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 04/07/2026
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back. It stated the resident was not cognitively able to rate pain scale. It stated the pain started on the night of 03/23/26. It stated she had memory loss-new or worsening, an abrupt decline in memory or mental status without other apparent symptoms and needs more assistance with activities of daily living including ambulation, bathing, bowel and bladder management, dressing, and transferring. Observations on 03/24/26 at 11:50 A.M. revealed emergency personnel entering Resident #155's room to transfer her to the hospital. Interview with LPN #223 on 03/26/26 at 12:10 P.M. revealed she was not Resident #155's nurse on 03/24/26 but management had asked her to fill out a change in condition evaluation form. She confirmed she put the pain started the night before because she had been hollering like that since the night before. She did not indicate how she knew this. She stated she heard her moaning out loud when she was walking down the hall around 9:30-10:00 A.M. on 03/24/26. She stated she went in the room and the resident indicated pain in her shoulder so she went to find the resident's nurse. She stated she could not find the nurse. She stated she was then told by the Director of Nursing to put a Lidocaine patch on the resident. She confirmed that this was not done until 11:20 A.M. She confirmed she did not document any assessment of the pain until she completed the change of condition form on 03/24/26 at 11:29 A.M. Interview with Nursing Assistant #246 on 03/30/26 at 7:05 A.M. revealed she worked dayshift on the day Resident #155 was sent to the hospital (03/24/26). She stated she came on duty at 6:00 A.M. and Resident #155 was having pain. She stated she was screaming and very vocal about pain. She stated she was complaining of pain in her shoulder area where it was broken. She stated she reported this to the dayshift nurse (came on duty at 7:00 A.M.) who said she only had Tylenol ordered to give. She stated the Tylenol did not work. She confirmed she did not report the pain to the nightshift nurse who was on duty until 7:00 A.M. On 03/30/26 at 12:55 P.M. Nursing Assistant #246 then stated she was not screaming at 6:00 A.M. but was just rather moaning out in pain. She stated she cleaned the resident up and got her up in the chair after coming on duty. Interview with Nursing Assistant #319 on 03/30/26 at 2:30 P.M. revealed she worked the night shift prior to Resident #155 going to the hospital on [DATE]. She stated the resident slept all night with no complaints of pain. Interview with Registered Nurse #238 on 03/30/26 at 12:40 P.M. revealed she was Resident #155's nurse on night shift prior to her going to the hospital on [DATE]. She stated the resident slept all night without complaints of pain. She stated she left at 7:30 A.M. and had nothing reported to her regarding pain before leaving. Review of the medication administration record revealed on 03/24/26 for the dayshift, LPN #404 documented the resident had no pain for the shift. (Even though she was sent to the hospital with uncontrollable pain). Review of hospital records for 03/24/26 revealed the resident was moaning in pain and was sent for complaints of diffuse body pain that was not alleviated with her pain medication. Review of the facility policy dated 2001 and revised July 2024 titled Pain-Clinical Protocol revealed the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. With input from the resident to the extent possible, the physician and staff will establish goals of pain treatment; for example freedom from pain with minimal medication side effects, or improved functioning, mood, and sleep. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain. The staff will monitor the individual's pain and related consequences at regular intervals dose of an existing analgesic, switching to another analgesic, and/or adding nonpharmacological measures.		

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 04/07/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor medications by completing physician order laboratory work for residents. This affected two (Resident #2 and #3) of five residents sampled for unnecessary medications. The facility census was 148.1. Review of Resident #2's medical record revealed an admission date of 11/01/23 and diagnoses including schizophrenia, drug induced subacute dyskinesia, diabetes, dementia, hypothyroidism, hyperlipidemia, and normal pressure hydrocephalus. Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] indicating the resident had severe cognitive impairment. Review of Resident #2's physician's orders revealed an order dated 01/25/24 for simvastatin 40 milligrams (MG) one tablet one time a day for hyperlipidemia. Review of Resident #2's pharmacy review recommendation dated 10/30/25 revealed a recommendation to get a fasting lipid panel (to monitor effectiveness of the medication) and liver function tests (to monitor for liver toxicity) related to the resident's use of cholesterol lowering medications. Further review of the pharmacy review recommendation revealed the physician responded to obtain the lipid panel and liver function tests on the next laboratory draw day and then to obtain the liver function tests every three months and the lipid panel once a year. Review of Resident #2's completed orders revealed an order dated 11/11/25 to obtain a lipid panel and LFT (liver function test) on night shift for one day. Review of Resident #2's laboratory reports revealed the lipid panel was completed on 11/12/25. Further review of Resident #2's laboratory reports revealed no results for the liver function test. In an interview on 03/31/2026 at 10:32 A.M. the Director of Nursing (DON) verified the liver function test was not completed in November or any time since. 2. Review of the record for Resident #3 revealed an admission date of 04/12/24 and diagnoses including diabetes, cerebral infarction, hypertension, Parkinson's disease, and chronic pain. Review of current physician's orders revealed the resident had received a long acting insulin (Glargine) 30 units daily since 05/27/25. An additional physician's order 08/08/24 included a quarterly check of the residents Hemoglobin A1C (a blood test to measure the average blood sugar levels over the past 2-3 months). There was no evidence a Hemoglobin A1C had been completed since 07/28/25. The result on 07/28/25 was 5.4 (normal 4.1-6.1). Interview with the Director of Nursing on 03/31/26 at 8:00 A.M. confirmed there was no evidence the Hemoglobin A1C had been completed since 07/28/25.		