

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/22/2025
NAME OF PROVIDER OR SUPPLIER  Buckeye Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  140 N State Street Westerville, OH 43081	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, and staff interview, the facility failed to maintain the facility in a safe, comfortable, and functional manner. This affected one (#22) of three residents reviewed for environment. The census was 58. Findings Include: Review of Resident #22's medical record revealed admission to the facility on [DATE]. Diagnoses included schizophrenia, seizures, morbid obesity, muscle weakness, personal history of transient ischemic attack, gastro-esophageal reflux disease, chronic pain syndrome, and difficulty walking. Review of Resident #22's Minimum Data Set (MDS) assessment, dated 06/16/25, revealed she had a severe cognitive impairment. Observation on 09/17/25 at 10:15 A.M. and 2:00 P.M., and on 09/18/25 at 6:15 A.M. and 9:30 A.M. revealed a large portion of Resident #22's wall was missing beside the right side of her bed. The approximate size of the hole in the wall (missing paint and drywall) was approximately three feet wide by two feet long. On 09/18/25, the facility began maintenance and replacement of the drywall in Resident #22's room. Interview with Certified Nurse Aide (CNA) #136 on 09/18/25 at 9:30 A.M. confirmed the large hole in Resident #22's wall. CNA #136 confirmed it had been that way for a while, but could not say exactly how long. CNA #136 agreed that based on the size of the hole in the drywall, it was something that took a while to happen, and most likely did not happen in a short period of time. She confirmed staff are to report any damage to resident rooms to the maintenance staff in a timely manner. Interview with Maintenance Staff (MS) #162 and the Administrator on 09/18/25 at approximately 1:00 P.M. confirmed the large hole/missing drywall in Resident #22's room. MS #162 and the Administrator confirmed they had no idea how the wall damage occurred and did not know how long it had been that way. MS #162 and the Administrator stated they were told about it by staff on 09/12/25, and they were working on getting the materials to fix it. They stated it could have been caused by staff running the bed into the wall and/or the resident reaching the hole and picking/pulling the drywall away. This deficiency represents non-compliance investigated under Master Complaint Number 2619510 and Complaint Number OH00167251 (1317248).</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER  Buckeye Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  140 N State Street Westerville, OH 43081	

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, resident and staff interview, and medical record review, the facility failed to ensure interventions for pressure relief were administered to residents with pressure ulcers as ordered. This affected one (#30) of three residents reviewed for pressure ulcers. The census was 58. Findings include: Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including acute kidney failure, muscle weakness, neuromuscular dysfunction of the bladder, and paraplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 13. The resident was assessed to require self-care assistance. Review of the care plan dated 07/14/25 revealed Resident #30 had multiple pressure ulcers due to immobility as a result of his paraplegia. Interventions included assisting the resident with turning and repositioning and weekly monitoring and treatment of his skin breakdown areas. Review of Resident #30's medical record revealed he had an unstageable pressure ulcer (obscured full-thickness skin and tissue breakdown) on his left heel. Review of Resident #30's current physician orders revealed an order for Prevalon boots (padded boots worn to keep the heels elevated to relieve pressure) to be applied every shift to prevent skin breakdown. Observation of Resident #30 on 09/17/25 at 12:30 P.M. and 3:15 P.M., and on 09/18/25 at 7:45 A.M., 12:11 P.M., and 3:03 P.M. revealed he was not wearing the Prevalon boots. During an interview with Resident #30 on 09/18/25 at 3:05 P.M. he confirmed the facility staff have not placed the boots on him in over one month. During an interview with Unit Manager #105 on 09/18/25 at 3:15 P.M. she confirmed Resident #30 was not wearing Prevalon boots as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00167373 (1317249) and Complaint Number OH00166868 (1317247).</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review, staff interview, and facility policy review, the facility failed to administer medications to residents in a timely manner as prescribed. This effected three (#54, #30, and #27) of five residents reviewed for medication administration. The facility census was 58. Findings include: 1. Record review for Resident #54 revealed the resident was admitted to the facility on [DATE] with the diagnoses including intraspinal abscess and granuloma, syphilis, anxiety, and bipolar disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to require self-care assistance. Review of Resident #54's current physician orders revealed an order for trazodone 50 milligrams (mg) to treat insomnia, due at 9:00 P.M. Review of Resident #54's medication administration record between 09/01/25 and 09/18/25 revealed trazodone was administered more than 90 minutes late on 09/02/25, 09/06/25, 09/07/25, 09/08/25, 09/09/25, 09/10/25, 09/16/25, and 09/17/25. 2. Record review for Resident #30 revealed the resident was admitted to the facility on [DATE] with the diagnoses including acute kidney failure, muscle weakness, neuromuscular dysfunction of the bladder, and paraplegia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 had intact cognition evidenced by a BIMS score of 13. The resident was assessed to require self-care assistance. Review of Resident #30's current physician orders revealed an order for oxycodone 5 mg to treat pain. Review of Resident #30's MAR between 09/01/25 and 09/18/25 revealed oxycodone was administered more than 90 minutes late on the nights of 09/03/25, 09/04/25, 09/05/25, 09/08/25, 09/09/25, 09/10/25, and 09/13/25. 3. Record review for Resident #27 revealed the resident was admitted to the facility on [DATE] with the diagnoses including left femur fracture, muscle weakness, dysphagia, and chronic kidney disease. The resident had allergies to codeine. Review of the admission MDS assessment dated [DATE] revealed Resident #27 had mildly impaired cognition evidenced by a BIMS score of 13. The resident was assessed to require assistance with self-care activities. Review of Resident #27's current physician orders revealed an order for gabapentin 100 mg scheduled for 9:00 P.M. for pain. Review of Resident #27's MAR between 09/01/25 and 09/18/25 revealed gabapentin was administered more than 90 minutes late on 09/08/25 and 09/11/25. Interview with Registered Nurse (RN) #131 stated medications are often administered late at night because of insufficient nursing staff and confirmed the medications were administered late for Resident #54, Resident #30, and Resident #27 on the dates listed for each resident as mentioned above. Review of a facility policy titled, Administering Medications, dated 12/12, revealed medications must be administered within one hour of the prescribed time. This deficiency represents non-compliance identified under Complaint Number OH00167251 (1317248).</p>		