

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/11/2025
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.			
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, resident interview, and facility policy review, the facility failed to obtain proper justification for decisions on pharmacy recommendations. This affected four (Residents #7, #9, #23 and #25) of five residents reviewed for unnecessary medications. Also, the facility failed to ensure there was proper monitoring/oversight for the use (unuse) of as needed pain medications. This affected one (Resident #23) of five residents reviewed for unnecessary medications. The census was 60.1. Resident #7 was admitted to the facility on [DATE]. His diagnoses were paranoid schizophrenia, muscle weakness, unspecified fracture of right ischium, neuromuscular dysfunction of bladder, dysphonia, hypertension, lack of coordination, insomnia, and xerosis cutis. Review of his minimum data set (MDS) assessment, dated 11/19/25, revealed he was cognitively intact. Review of Resident #7 Consultant Pharmacist Recommendation to Prescriber report, dated 11/23/25, revealed a recommendation for a gradual dose reduction for Risperdal three milligrams (mg) each night. The nurse practitioner reviewed and disagreed with the recommendation on 11/26/25. There was no justification or explanation documented as to why the recommendation was declined. 2. Resident #23 was admitted to the facility on [DATE]. Her diagnoses were type II diabetes, muscle weakness, morbid obesity, major depressive disorder, hyperlipidemia, schizoaffective disorder, psychosis, insomnia, dementia, hallucinations, delusional disorder, and age-related nuclear cataract. Review of her MDS assessment, dated 09/19/25, revealed she was cognitively intact. Review of Resident #23 Consultant Pharmacist Recommendation to Prescriber report, dated 02/06/25, revealed a recommendation for a gradual dose reduction for melatonin six mg at bed time to three mg at bed time for insomnia. The nurse practitioner reviewed and disagreed with the recommendation on 02/07/26. There was no justification or explanation documented as to why the recommendation was declined. Interview with Regional Director of Clinical Services (RDCS) #189 on 12/11/25 at 1:10 P.M. confirmed there were no documented justifications on the above pharmacy recommendations. She confirmed there should be a written justification as to why the recommendations were declined. 3. Review of the medical record for Resident #25 revealed an admission date of 09/05/2024. Diagnoses included generalized anxiety, mood disorder, insomnia, and schizoaffective disorder Bipolar type. Review of Resident #25's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating an intact cognition for daily (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
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decision making abilities. Resident #25 was noted to receive antipsychotic and antidepressants on a daily basis. A gradual dose reduction for the antipsychotics received were noted as being clinically contraindicated by the physician. Review of Resident #25's physician orders revealed a current order for Trazadone Hydrochloride (hcl) (a antidepressant often used to treat insomnia and anxiety) 50 milligrams (mg) to be given daily for insomnia. There was also an order noted for Zoloft (a antidepressant) 50 mg to be taken daily for anxiety disorder. Review of the pharmacy review for January 2025 revealed there was a recommendation for Resident #25's Trazodone 50 mg to be re-evaluated to determine the medicinal need of this therapy. Continued review showed the physician (unable to determine who the physician was) noted on 01/13/2025 that they disagreed with this recommendation but not rational was provided as to why. Review of the pharmacy recommendation for September 2025 revealed the pharmacy recommended that Resident #25's Trazodone 50 mg and Zoloft 100 mg be reduced. Please consider a trial dose reduction at this time. If a gradual dose reduction is contraindicated at this time, please document the clinical rational below. This must address the reason(s) why an attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Continued reviewed revealed the physician (Unable to determine who the physician was) disagreed with this recommendation on 10/12/2025. 4. Review of the medical record for Resident #9 revealed an admission date of 11/05/2025. Diagnosis included cellulitis of the perineum, muscle weakness, and a non-pressure chronic ulcer of the left ankle. Review of Resident #9's admission MDS 3.0 assessment dated [DATE] revealed a BIMS score of 13 out of 15 indicating an intact cognition for daily decision making abilities. Resident #9 was noted to receive antibiotics on a daily basis. Review of Resident #9's current physician orders revealed a order for Daptomycin-sodium chloride (a pre mixed intravenous antibiotic solution to treat serious bacterial infections) intravenous solution, 700-0.9 milligrams per every 100 milliliter. Use 700 mg intravenously daily for right ankle wound infection for 6 weeks. Review of the pharmacy monthly review and recommendations for November 2025 revealed Resident #9 was currently on Daptomycin 700 mg daily. Please consider monitoring CK levels frequently (weekly) until Daptomycin course is finished. Continued review showed a physician (unable to determine who the physician was) noted to disagree with this recommendation on 11/10/2025. 5. Review of Resident #23 current physician orders revealed the following as needed pain medications ordered: Motrin 800 mg by mouth every eight hours as needed for pain, Norco 5-325 mg every eight hours as needed for pain, and Tylenol 650 mg every four hours as needed for pain. Review of Resident #23 medication administration records (MAR), dated July 2025 to December 2025, revealed Motrin and Norco had not been administered during this entire time frame. Review of Resident #23 pharmacy recommendations, dated July 2025 to November 2025, revealed there were no recommendations and/or documentation from the pharmacy to discuss why these two (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as needed pain medications were still ordered if they were not being administered. Interview with Director of Nursing (DON) on 12/11/25 at 12:45 P.M. confirmed Resident #23 requests to have Tylenol as her as needed pain medication. She is cognitively intact enough to make this decision, even when the pain level is outside the parameters designed for Tylenol. When asked why Motrin and Norco are still available and on her current physician orders if she chooses not to use them, or why pharmacy didn't have a documented review for either unused medication, she stated she didn't have an answer. Interview with Resident #23 on 12/11/25 at 12:55 P.M. confirmed she prefers to have Tylenol as her pain medications, because she said, the medications I'm on don't work as well as Tylenol does, and they would rather receive Tylenol over the other as needed pain medications she has ordered. She confirmed she does not request to have Motrin or Norco. Review of facility Medication Regimen Reviews policy, dated April 2007, revealed the consultant pharmacist shall review the medication regimen of each resident at least monthly. As a part of the medication regimen review, the consultant pharmacist will determine if the resident is receiving the correct medications as ordered, determine if medications are administered in the correct dosage and form, and be alert to medications with potentially significant medication-related adverse consequences and to actual signs and symptoms that could represent adverse consequences. The consultant pharmacist will provide a written report to physicians for each resident with an identified irregularity. If the physician does not provide a pertinent response, or the consultant pharmacist identifies that no action has been taken, he/she will then contact the medical director, or - if the medical director is the physician of record - the administrator. The consultant pharmacist will provide the director of nursing and medical director with a written, signed, and dated copy of the report, listing irregularities found and recommendations for their solutions.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and medical record review, the facility failed to ensure the blood glucose meter was sanitized after use for Resident # 39. This had the potential to affect six residents identified by the facility as receiving blood glucose monitoring from the East Hall nurse. The facility census was 60. Review of Resident # 39's medical record revealed he was admitted on [DATE] with diagnoses that included diabetes mellitus type 1, morbid obesity, hypertension and cholecystitis. Review of Resident # 39's Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact and that he required assistance from staff with toileting, transfers, dressing and personal hygiene. Review of Resident # 39's December 2025 physicians orders revealed the following pertinent orders: -Accu Check (type of blood glucose monitor) in the morning every other day for diabetes. -Disinfect glucometer (blood glucose meter) between each use every shift for infection control. -Disinfect glucometer between each use as needed for infection control. Observation of medication administration on 12/10/2025 at 8:30 A.M. with Registered Nurse (RN) # 207 revealed RN # 207 used a glucometer to obtain a blood sugar reading for Resident # 39; she then wiped the glucometer with an alcohol pad. Further observation revealed RN # 207 then wiped the glucometer with a bleach wipe and placed it in the top drawer of the nurse's cart. Interview on 12/10/25 at 8:35 A.M. with RN # 207 revealed the glucometer used was one of two glucometers shared for her assignment. RN # 207 confirmed she wiped the glucometer with a bleach wipe and did not let the glucometer remain visibly wet for 4 minutes as the instructions for disinfecting stated on the bleach wipes. Review of Safety Data Sheet for PDI Sani-Cloth Bleach Germicidal Disposable Wipes dated 08/12/16, revealed it is recommended for use as a disinfectant on hard, non- porous surfaces and should be used only according to label directions. Review of directions for disinfecting revealed to disinfect; allow surface to remain visibly wet for four minutes. Use additional wipes if needed, to ensure continuous four-minute wet contact time. Let air dry.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview and staff interviews, the facility failed to ensure timely and adequate vision services were provided to Resident #26. This affected one (Resident #26) out of one resident reviewed for communication and sensory problems. Facility census was 60. Review of Resident # 26's medical record revealed an admission date of 06/07/25 with diagnoses that included but were not limited to left femur fracture, asthma, diabetes type 2 with diabetic neuropathy, chronic diastolic heart failure and need for assistance with personal care. Review of Resident #26's Minimum Data Set (MDS) dated [DATE], revealed a BIMS score of 14 out of 15 indicating intact cognition and that she required assistance from staff with toileting, showering/bathing and dressing. Review of Resident # 26's progress notes dated November 2025 to December 2025, revealed no documentation for offering of ancillary services or residents request to be seen by an optometrist. Observation and interview on 12/10/15 at 12:27 P.M. with Resident # 26 revealed resident wearing glasses with a piece of white tape visible on the middle of the frame on the nose pieces. Further interview with Resident # 26 revealed the eye pads on her glasses had been broken for about a month and she requested to an unidentified nurse that she wanted to see the eye doctor to get her glasses fixed, and she was still waiting for someone to come and help her set up an appointment. Interview on 12/11/25 at 9:15 A.M. with the Director of Nursing (DON) revealed she was unaware that Resident # 26 had broken glasses and had requested to be seen by the optometrist. Further interview revealed there was currently no social service director at the facility and scheduling of appointments were handled by the Human Resources Director (HRD) #225. Interview on 12/11/25 at 1:15 P.M. with HRD # 225 revealed the facility did not have evidence of tracking residents to be seen for ancillary services or evidence that residents were offered consents for ancillary services. HRD #225 stated that residents need to have signed consent to be seen and after they consent, they are put on the list and seen by the provider on the next visit or facility will schedule with an outside provider. HRD #225 confirmed that Resident # 26 did not have a consent for ancillary services and has never received or assisted with scheduling ancillary services by the facility. This deficiency represents non-compliance investigated under Complaint Number 2676801.		

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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 medical record review and staff interview, the facility failed to provide effective pain management for Resident # 18. This affected one (Resident #18) out of four residents reviewed for pain management. The facility census was 60. Review of Resident # 18's medical record revealed she was admitted on [DATE] with diagnoses that included chronic pain syndrome, anxiety, depression, polyneuropathy and irritable bowel syndrome. Review of Resident # 18's Minimum Data Set (MDS) dated [DATE], revealed resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition and required assistance from staff with showering and bathing. Review of Resident # 18's Physician's Orders dated December 2025, revealed the following orders: -Oxycodone (medication used for moderate to severe pain) HCL Oral tablet 5 mg (milligrams); give one tablet every four hours as needed (PRN) for pain level 1-10. -Gabapentin (medication used for nerve pain) Oral tablet 600 mg; give one tablet three times a day for neuropathy (nerve pain) and- Pain Assessment/Pain monitor every shift for pain management. Review of Resident # 18's Medication Administration Records (MAR) dated August 2025 to December 2025, revealed the PRN Oxycodone for Resident # 18 was given and reported to the nurse as ineffective on 08/06/25- pain level 5, 08/09/25- pain level 5, 08/18/25- pain level 6, 08/19/25- pain level 6, 09/14/25- pain level 7, 11/16/25- pain level 7 and 12/08/25- pain level 7. Review of Resident # 18's progress notes dated August 2025 to December 2025 revealed no documentation regarding follow up interventions or physician notification after episodes of ineffective pain management. Interview on 12/11/2025 at 11:41 A.M. with Director of Nursing (DON) revealed her expectation for nurses to manage residents who report PRN pain medication was ineffective, was that they should offer other non-pharmacological interventions and attempt to get to the root cause of pain, then call physician to get a temporary solution to manage the residents' immediate pain. DON confirmed dates for ineffective pain management on the MAR and no follow up documentation in the medical record.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to a psychiatric consult as ordered. This affected one (Resident #43) of four residents reviewed for behavioral services. The census was 60. Resident #43 was admitted to the facility on [DATE]. His diagnoses were chronic obstructive pulmonary disease, depression, hyperlipidemia, hypertension, alcohol abuse, polyneuropathy, and gastro-esophageal reflux disease (GERD). Review of his minimum data set (MDS) assessment, dated 09/15/25, revealed he was cognitively intact. Review of Resident #43 physician orders, dated 08/13/25, revealed there was a psychiatric evaluation that was ordered to be completed. Review of Resident #43 medical records, dated 08/13/25 to 11/24/25 (date of discharge), revealed there was no completed psychiatric evaluation. Interview with Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #189 on 12/11/25 at 11:38 A.M. and 1:00 P.M. confirmed there was no completed psychiatric consult for Resident #43. RDCS #189 confirmed the psychiatric consult is a standing order that is put into everyone's orders when they are admitted to the facility; she confirmed not all of them are completed. Both confirmed there was no documentation to support a conversation with Resident #43 or his family regarding the psychiatric consult and whether it should or should not be completed. This deficiency represents non-compliance investigated with complaint number 2660184.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to maintain hospice notes and records on-site for all residents. This affected one (Resident #31) of one resident reviewed for hospice services. The census was 60. Resident #31 was admitted to the facility on [DATE]. Her diagnoses were hemiplegia, vitamin D deficiency, osteoarthritis of knee, osteoporosis, hypertension, rheumatic heart disease, and dementia. Review of her minimum data set (MDS) assessment, dated 10/02/25, revealed she had a severe cognitive impairment. Review of Resident #31 hospice records in the facility, found there were no hospice notes in their physical hospice binder for the last three months. Review of Resident #31 hospice notes, dated 09/15/25 to 11/26/25, revealed all these hospice notes and records were delivered to the facility by the hospice agency on 12/10/25. Interview with Regional Director of Clinical Services (RCDS) #189 on 12/11/25 at 1:10 P.M. confirmed they received the hospice notes from the hospice agency for Resident #23 on 12/10/25. She confirmed they should have those documents in the facility.		