STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365228	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmington Nursing & Rehab	75 Hale Street Wilmington, OH 45177

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, record review, interview and review of facilty policy, the facility failed to provide proper incontinence care to one (#48) out of one residents reviewed for incontinence care. The facility census was 63.Findings include: Record review for Resident #48 revealed this resident was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, muscle weakness, and radiculopathy lumbar region. Review of the MDS assessment dated [DATE] revealed the resident had severely impaired cognition. This resident was assessed to require to be dependent on staff for all activities of daily living (ADLs). Resident is assessed to always be incontinent of bowel and bladder.Observation on 06/10/26 at 9:23 A.M revealed CNA #260 put on a gown and applied gloves. She then put clean washcloths in Resident #48's sink and turned the water on. CNA #260 sat the washcloths on the bedside table on top of a new garbage bag. CNA #260 removed Resident #48's covers and clothes with the same gloves and started to provide incontinence care. CNA #260 cleaned Resident #48's peri area with washcloths with just water on them and then dried the resident with clean, dry washcloths. After completing incontinence care CNA #260 put a clean brief on Resident #48 and readjusted her in bed with the help from RN #265. After, incontinence care was completed CNA #260 kept the same gloves on and turned the sink faucet on. CNA #260 removed their gloves and proceeded to wash their hands.Interview on 06/10/26 at 9:27 A.M with CNA #260 confirmed they are supposed to use two basins to provide incontinence care, one with water and another with soap and water. They are supposed to wash their hands before and after incontinence care. CNA #260 confirmed they did not wash their hands before performing incontinence care and that they did not apply soap to the wet washcloths and only used water to clean up the resident.Review of the facility policy titled Perineal Care Incontinent Care Procedure, dated on 10/30/25, revealed staff members are supposed to have a basin and soap or a no rinse incontinent cleanser. Staff members are supposed to perform hand hygiene prior to performing incontinent care and fill the wash basin with water.This deficiency represents non-compliance investigated under Complaint Number 2979996, 2686679, and 2670922.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interviews, record review, and policy review, the facility failed to provide timely pain management for one (#85) out of three residents reviewed for pain management. The facility census was 63. Findings include:Review of medical records for Resident #85 revealed an admission date of 06/08/26 at 11:30 P.M. Diagnoses included complete traumatic amputation hip and knee, peripheral vascular disease, type two diabetes, and abdominal hernia without obstruction or gangrene. Review of the physician orders dated 06/09/26 revealed Resident #85 had an order for Tylenol 325 milligram (mg) two tablets every six hours routine. Times to be administered were 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M. Also, Resident #85 had an order for oxycodone/acetaminophen 10-325 mg take one tablet as needed every six hours. Review of the medication administration record dated 06/09/26 revealed that Resident #85 had not been administered Tylenol 325 mg two tablets at 12:00 P.M. Review of Resident #85's vital sign form revealed on 06/09/26 at 2:16 P.M. the resident's pain was assessed to be zero out of 10 pain (zero being no pain and 10 being the worst pain ever) Review of the medication administration record dated 06/09/26 revealed the pain assessment for day shift time, 7:00 A.M. through 7:00 P.M., documented Resident #85's pain was marked a zero. Non-pharmacological intervention provided was marked for rest. Observation and interview on 06/09/26 at 2:20 P.M. Resident #85 was sitting up in her wheelchair. Resident #85 made a groan noise. Resident #85 stated she had alot of pain in her left leg from her amputation. Resident #85 stated the last time she had received pain medication was the prior night and she was given Tylenol. Resident #85 stated she was supposed to be getting oxycodone/acetaminophen 10 mg-325 mg and she was taking is at the hospital before she came. Resident #85 had stated the nurse the prior night said she was ordering the medication right away so it would be here in this morning. Resident #85 stated she had not received any oxycodone/acetaminophen at the facility and has only been given Tylenol. Resident #85 stated the nurse had spoken to her this morning and stated she had no oxycodone/acetaminophen 10 mg-325 mg in her cart. The nurse had told her she was going to call the pharmacy to see where the medication was. Resident #85 stated Registered Nurse (RN) #301 had told her she had no order for Tylenol. Resident #85 stated her pain right now was an eight out of 10 on the pain scale. Resident #85 stated eight was the pain number this morning when she reported her pain to RN #301. Resident #85 stated the nurse had not done anything for her pain. Interview on 06/09/26 at 2:39 P.M. with RN #301 verified Resident #85 had reported her pain level for her left leg amputation was eight out of 10 on the pain scale this morning around 10:00 A.M. or 10:30 A.M. RN #301 stated she told Resident #85 she would follow up and call the pharmacy for her narcotic pain medication. RN #301 stated she had called the pharmacy a few times and on the last call they had stated it was on the way. RN #301 did not call the physician to ask about a different medication. RN #301 verified she had not provided any pain interventions to Resident #85. RN #301 stated the aid had gotten her out of bed to help with pain. RN #85 stated recently Resident #85 had reported her pain was still eight out of 10 on the pain scale. Observation on 06/09/26 at 2:50 P.M. revealed Resident #85's oxycodone/acetaminophen 10-325 mg was delivered. Additional chart review of the medication administration record dated 06/09/26 revealed Resident #85 had received oxycodone/acetaminophen 10-325 mg at 2:54 P.M.Observation on 06/09/26 at 2:55 P.M. with the Director of Nursing (DON) of the Omnicell medication dispenser for stock medications revealed no oxycodone/acetaminophen 10-325mg were in stock. Interview on 06/09/26 at 2:55 P.M. the DON verified the Omnicell medication dispenser had oxycodone 5 mg and oxycodone 10 mg immediate release available. The DON stated if a physician was notified there were other medications available to use for managing pain. Interview on 06/09/26 at 4:42 P.M. RN #301 stated she looked and didn't see an order on the medication administration record for Tylenol for Resident #85. RN #301 stated she now sees the order for the Tylenol routinely. RN #301 confirmed Resident #85 did not receive her Tylenol 325 mg at 12:00 P.M. Interview on 06/09/26 at 5:00 P.M. the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated she expected all nurses to administer medication timely and per physician's order to manage resident's pain. The DON stated RN #301 should have called the physician for a new order and recommendation for Resident #85 when she was reporting pain and her pain medication ordered was not available. Review of the facility policy titled General Dose Preparation and Medication Administration, date 12/01/2007, revealed prior to administration of medication, facility staff should verify the correct medication, at the correct dose, at the correct time, for the correct resident. Administer medications within time frames specified by facility policy. Review of the facility policy titled Pain Management Protocol, dated 11/19/2025, revealed the physician or provider will be notified of new onset of pain or significant increase in pain as appropriate. Non-pharmacological interventions will be attempted prior to the administration of as needed pain medications. If non-pharmacological interventions fail then when as needed medications are available with corresponding intensity ratings, the resident will be administered the medication ordered for the corresponding pain rating within the as needed order.This deficiency represents non-compliance with Complaint Number 2710111.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, interview, and facility policy, the facility failed to ensure medications were administered with a medication error rate less then 5%. This affected three (#28, #41, and #62) residents observed during medication administration. A total of 29 medication opportunities with three errors were observed for total error rate of 10%. The facility census was 63. Findings include: 1.Review of the medical records for Resident #28 revealed an admission date of 01/03/25. Diagnoses included dementia, peripheral vascular disease, and Alzheimer's disease. Review of physician orders dated 02/18/26 revealed Resident #28 had an order memantine 5 milligrams (mg) two tablets twice a day. Observation on 06/10/26 from 7:20 A.M. through 7:26 A.M. with Registered Nurse (RN) #274 revealed she administered medications to Resident #28. Medications administered included aspirin 81 mg one tablet, furosemide 20 mg one tablet, memantine 10 mg two tablets, and tamsulosin hydrochloride (HCL) 0.4 micrograms (mcg) one tablet. Interview on 06/10/26 at 10:10 A.M. RN #274 verified she administered two tables of memantine 10 mg to Resident #28, for a total dose of 20 mg. RN #274 verified Resident #28's physician order was for memantine 5 mg take two tablets. RN #274 verified the medication card had memantine 10 mg one tablet on the label. 2.Review of medical records revealed Resident #41 had admission date of 04/29/24. Diagnoses included Parkinson's disease with dyskinesia and moderate protein calorie malnutrition. Review of physician order dated 05/27/26 revealed Resident #41 had an order for cimetidine 200 mg two tablets every day. Observation on 06/10/26 from 7:28 A.M. through 7:31 A.M. with RN #274 administered medication to Resident #41. Medications administered included: carbidopa-levodopa 25-100 mg one tablet, cimetidine 200 mg one tablet, memantine 10 mg one tablet, citalopram 100 mg one tablet, and medroxyprogesterone acetate 10 mg three tablets. Interview on 06/10/26 at 10:10 A.M. RN #274 verified Resident #41 had a physician order for cimetidine 200 mg take two tablets. 3.Review of medical record for Resident #62 revealed an admission of 04/30/26. Diagnoses included type two diabetes, morbid obesity, anemia, and depression. Review of physician's order dated 05/01/26 revealed Resident #62 had an order to take furosemide 20 mg two tablets every day. Observation on 06/10/26 from 7:55 A.M. through 8:08 A.M. with RN #273 administered medication to Resident #62. Medications administered included the following: aspirin 81 mg one tablet, cetirizine 10 mg one tablet, Vitamin D3 25 mcg two tablets, Plavix 75 mg one tablet, Vitamin B-12 100 mg gave five tablets, famotidine 20 mg one tablet, iron 325 (65 mg) one tablet, furosemide 20 mg one tablet, glipizide 5 mg extended release one tablet, Jardiance 25 mg one tablet, losartan potassium 100 mg one tablet, Magnesium oxide 400 mg one tablet, metformin 500 mg one tablet, metoprolol succinate extended release 25 mg one tablet, and MiraLAX 17 grams in water. Interview on 06/10/26 at 10:20 A.M. RN #273 verified Resident #62 had only received furosemide 20 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg one tablet with the morning medication. RN #273 verified Resident #62 had a physician order for furosemide 20 mg take two tablets. There were a total of three medication errors out of 29 opportunities for error for a medication error rate of 10 %. Review of the facility document titled General Dose Preparation and Medication Administration, dated 12/01/2007, revealed staff should verify each time a medication was administered that it was the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. This deficiency represents non-compliance investigated under Complaint Numbers 2742658, 2701109, 2686679, 2670992, and 2710111.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, record review, and facility policy, the facility failed to be free from significant medication errors for one (#62) resident observed for medication administration. The facility failed to administer medications per physician order for one (#85) out of three residents reviewed for pain management. The facility census was 63. Findings include: 1. Review of medical records for Resident #85 revealed an admission date of 06/08/26 at 11:30 P.M. Diagnoses included complete traumatic amputation hip and knee, peripheral vascular disease, type two diabetes, and abdominal hernia without obstruction or gangrene. Review of the physician orders dated 06/09/26 revealed Resident #85 had an order for Tylenol 325 milligram (mg) two tablets every six hours routine. Times to be administered were 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M. Review of the medication administration record dated 06/09/26 revealed that Resident #85 had not been administered Tylenol 325 mg two tablets at 12:00 P.M.Interview on 06/09/26 at 2:20 P.M. Resident #85 stated she had alot of pain in her left leg from her amputation. Resident #85 stated the last time she had received pain medication was the prior night and she was given Tylenol. Resident #85 stated Registered Nurse (RN) #301 had told her she had no order for Tylenol. Resident #85 stated her pain right now was an eight out of 10 on the pain scale. Interview on 06/09/26 at 4:42 P.M. RN #301 stated she looked and didn't see an order on the medication administration record for Tylenol for Resident #85. RN #301 stated she now sees the order for the Tylenol routinely. RN #301 confirmed Resident #85 did not receive her Tylenol 325 mg at 12:00 P.M. Interview on 06/09/26 at 5:00 P.M. the DON stated she expected all nurses to administer medication timely and per physician's order to manage resident's pain. Review of the facility policy titled General Dose Preparation and Medication Administration, date 12/01/2007, revealed prior to administration of medication, facility staff should verify the correct medication, at the correct dose, at the correct time, for the correct resident. Administer medications within time frames specified by facility policy. 2. Review of medical record for Resident #62 revealed an admission of 04/30/26. Diagnoses included type two diabetes, morbid obesity, anemia, and depression. Review of physician's order dated 05/01/26 revealed Resident #62 had an order to take furosemide 20 mg two tablets every day. Observation on 06/10/26 from 7:55 A.M. through 8:08 A.M. with RN #273 administered medication to Resident #62. Medications administered included the following: aspirin 81 mg one tablet, cetirizine 10 mg one tablet, Vitamin D3 25 mcg two tablets, Plavix 75 mg one tablet, Vitamin B-12 100 mg gave five tablets, famotidine 20 mg one tablet, iron 325 (65 mg) one tablet, furosemide 20 mg one tablet, glipizide 5 mg extended release one tablet, Jardiance 25 mg one tablet, losartan potassium 100 mg one tablet, Magnesium oxide 400 mg one tablet, metformin 500 mg one tablet, metoprolol succinate extended release 25 mg one tablet, and MiraLAX 17 grams in water. Interview on 06/10/26 at 10:20 A.M. RN #273 verified Resident #62 had only received furosemide 20 mg one tablet with the morning medication. RN #273 verified Resident #62 had a physician order for furosemide 20 mg take two tablets. This deficiency represents non-compliance investigated under Complaint Numbers 2742658, 2701109, 2686679, 2670992, and 2710111.