STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365425	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newark Nursing & Rehab	75 McMillen Drive Newark, OH 43055

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 Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review, staff interview, and review of the facility policy, the facility failed to provide resident and resident representatives with written notice of discharge. This affected one (Resident #116) of three residents reviewed for resident rights. The facility census was 115 residents. Findings include:Review of the medical record for Resident #116 revealed an admission date of 03/19/26 with diagnoses including Alzheimer's disease, chronic kidney disease, and mood disorder and a discharge date of 04/13/26. Review of the Minimum Data Set (MDS) assessment for Resident #116 dated 03/25/26 revealed the resident had severe cognitive impairment. Review of the discharge not anticipated MDS assessment for Resident #116 dated 04/13/26 revealed the resident was discharged from the facility. Review of the hospice note for Resident #116 dated 03/18/26 revealed the resident was being admitted to the facility for permanent placement. Review of the hospice note for Resident #116 dated 04/07/26 revealed Resident #116's wife had called hospice saying the facility stated Resident #116 had to be discharged to a psychiatric facility due to his behaviors. Review of an email from hospice Licensed Social Worker (LSW) #182 to the facility Administrator dated 04/08/26 revealed Resident #116's wife had notified hospice of the facility's intent to discharge the resident to a psychiatric facility. LSW #182 indicated the facility had not issued a 30-day discharge notice to the resident's wife. Interview on 05/12/26 at 1:56 P.M. with the Administrator confirmed the facility verbally notified Resident #116's wife the facility wanted to discharge the resident to a psychiatric facility due to his behaviors, but the facility had not issued a written 30-day discharge notice. Interview on 05/12/26 at 2:51 P.M. with LSW #219 stated Resident #116 had been to the facility prior for respite stays but had come to the facility 03/19/26 for a permanent placement. LSW #219 stated the Administrator told her Resident #116 needed to be discharged from the facility but she was unsure why the resident needed to be discharged . LSW #219 stated she did send a packet of information to hospice because they were looking for placement for Resident #116. Interview on 05/13/26 at 12:36 P.M. with Regional Director of Clinical Services (RDCS) # 187 confirmed Resident #116 needed to be discharged from the facility because the resident had been involved in four resident to resident altercations without resident injury. RDCS #187 stated there was concern that Resident #116 might possibly injure another resident in the future if he were permitted to stay. Interview on 05/13/26 at 3:52 P.M. with Medical Director # 188 verified she saw Resident #116 on 03/25/26 and was not notified of any problem behaviors from 03/19/26 to 04/13/26. Review of the facility policy titled Transfer or discharge date d December 2016 revealed the facility would provide a resident and/or the resident's representative (sponsor) with a thirty (30) day written notice of impending discharge.Review of the facility Admissions Packet undated revealed the facility would notify the resident and resident's representative in writing in advance of any proposed transfer or discharge from the facility. The facility would also send a copy of the notice to the Ohio Department of Health and the state long-term care ombudsman. This deficiency represents noncompliance investigated under Complaint Number 2982628.

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on medical record review, staff interview, and review of the facility policy, the facility failed to implement behavioral management interventions for dementia residents. This affected one (Resident #116) of three residents reviewed for behavior management. The facility census was 115 residents.Findings include:Review of the medical record for Resident #116 revealed an admission date of 03/19/26 with diagnoses including Alzheimer's disease, chronic kidney disease, and mood disorder. Review of the Minimum Data Set (MDS) assessment for Resident #116 dated 04/13/26 revealed the resident had severe cognitive impairment, was dependent on staff assistance with activities of daily living (ADLs), received antianxiety and antidepressant medications, and exhibited verbal and physical behavioral symptoms. Review of the care plan for Resident #116 revealed the resident had behavior problems related to Alzheimer's disease which included wandering and physical and verbal aggression towards other residents. Interventions included staff should administer psychotropic medications as ordered and observe for effectiveness of the medications. Review of the physician's orders for Resident #116 revealed orders dated 03/20/26 for Ativan 0.5 milligrams (mg) every eight hours as needed for agitation for 14 days and for hydroxyzine 25 mg every 6 hours as needed for agitation for 14 days. Review of the progress note for Resident #116 dated 03/23/26 at 07:56 A.M. revealed the resident had been up and was wandering the hallways. Staff tried to redirect the resident to not enter other resident rooms and to take breaks, but the resident refused and continued to pace the hallways. Review of the progress note for Resident #116 dated 03/23/26 at 1:56 P.M. revealed the resident was rocking back and forth in front of a female resident and her visitor. Staff placed the resident on 15-minute checks. Review of the Medication Administration Record (MAR) for Resident #116 dated March 2026 revealed on 03/23/26 the resident was documented as having no behaviors and did not receive as needed Ativan or hydroxyzine. Review of the Medical Director note for Resident #116 dated 03/25/26 revealed the resident was calm and cooperative and staff should continue to administer Ativan as needed for anxiety. Review of the progress note for Resident #116 dated 03/29/26 at 6:29 A.M. revealed the resident was combative with aides during care. There was no documentation of staff interventions related to the resident's behavior. Review of the MAR for Resident #116 dated March 2026 revealed 03/29/26 the resident was documented as having no behaviors and did not receive as needed Ativan or hydroxyzine. Review of the progress note for Resident #116 dated 03/31/26 at 2:10 P.M. revealed the resident was involved in an altercation with another resident where he pulled the other resident's hair. There was no documentation of staff interventions related to the resident's behavior. Review of the MAR for Resident #116 dated March 2026 revealed the resident was documented as having no behaviors on day shift. Interview on 05/12/26 at 9:59 A.M. with the Assistant Director of Nursing (ADON) confirmed Resident #116 had behaviors on 03/23/26 and the resident may have been agitated. The ADON verified Resident #116 did not receive as needed Ativan or hydroxyzine on 03/23/26 and no behaviors were documented on the MAR. ADON stated she did not think Resident #116's medication management for his behaviors was appropriate during the time frame of 03/19/26 to 04/13/26. Interview on 05/13/26 at 12:36 P.M. Regional Director of Clinical Services (RDCS) # 187 confirmed Resident #116's behavioral medications could have been better managed. Interview on 05/13/26 at 1:42 P.M. with Nurse Practitioner (NP) #185 verified he did not see Resident #116 during 03/19/26 to 04/13/26 and was not notified of any behaviors for the resident. Interview on 05/13/26 at 3:52 P.M. with the Medical Director verified she saw Resident #116 on 03/25/26 but was not notified of any of his behaviors during 03/19/26 to 04/13/26. Review of the facility policy titled Behavioral Assessment, Intervention and Monitoring dated March 2019 revealed the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	assessment and plan of care. The interdisciplinary team would evaluate behavioral symptoms in residents to determine the degrees of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies would be implemented immediately if necessary to protect the resident and others from harm. This deficiency represents noncompliance investigated under Complaint Number 2982628.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation staff interview, and review of the facility policy, the facility failed to ensure staff practiced proper hand hygiene during care. This affected two residents (Resident #58 and #74) of the three residents reviewed for wounds and incontinence care. The facility census was 115 residents.Findings include: 1.Review of the medical record for Resident #58 revealed an admission date of 04/28/26 with diagnoses including hemiplegia and hemiparesis following cerebral infarction, vascular dementia, and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment for Resident #58 dated 04/07/26 revealed the resident was cognitively intact, was frequently incontinent of bowel and bladder, and required staff assistance with toiletingReview of the physician's order for Resident #58 revealed an order dated 05/02/26 for wound care to the left lower extremity to cleanse with normal saline or wound cleanser, apply adaptic to the wound bed, cover with two abdominal (ABD) pads, wrap with Kerlix and secure with tape daily and as needed until resolved.Observation on 05/12/26 at 2:25 P.M. of incontinence care provided for Resident #58 per Certified Nursing Assistant (CNA) #180 revealed the aide donned gloves, entered the resident's room, set up for incontinence care, and then provided incontinence care for the resident. At no time did the CNA perform hand hygiene.Interview on 05/12/26 at 2:35 P.M. with CNA #180 confirmed she did not change gloves or perform hand hygiene once she entered Resident #58's room and verified she had touched multiple items before performing incontinence care for the resident.Observation on 05/12/26 at 2:38 P.M. of wound care for Resident #58 per by Licensed Practical Nurse (LPN) # 130 and Registered Nurse (RN) # 375 revealed LPN #130 removed the old dressing from the resident's left lower leg and then removed her gloves and donned a new pair of gloves. RN # 375 wore cleansed the wound with wound cleanser. LPN #130 then applied adaptic to the resident's left lower leg, covered the adaptic with an ABD, wrapped the leg with Kerlix, and secured the dressing with tape. Interview on 05/12/26 at 2:46 P.M. with LPN #130 verified she had changed gloves after removing the old dressing from Resident #58's left lower leg and did not wash her hands or use hand sanitizer before putting on a new pair of gloves prior to applying dressing to Resident #58's left lower leg. 3.Review of the medical record for Resident #74 revealed an admission date of 01/28/26 with diagnoses including pressure ulcer of right buttock, anxiety disorder, and paraplegia. Review of the MDS assessment for Resident #74 dated 05/06/26 revealed the resident was cognitively intact and was dependent on staff for all activities of daily living (ADLs.) Review of the care plan for Resident #74 revealed the resident required enhanced barrier precautions (EBP) related to risk for multi-drug-resistant organism (MDRO) infections related to indwelling device, gastrostomy (g-tube).Review of the physician's orders for Resident #74 dated May 2026 revealed an order to cleanse the g-tube site with soap and water, pat dry, and leave open to air every day.Observation on 05/12/26 at 11:20 A.M. of g-tube care for Resident #74 per LPN # 186 revealed the nurse did not a gown prior to entering the resident's room. LPN #186 donned gloves but did not wash her hands or use hand sanitizer and then removed the soiled dressing from the resident's g-tube, cleansed the tube site with soap and water, changed gloves, and applied a new g-tube dressing. Interview on 05/12/26 at 11:29 A.M. with LPN #186 verified Resident #74 was on EBP and she had not donned a gown prior to entering the resident's room. LPN #186 confirmed she did not wash her hands or use hand sanitizer when entering the room and when she changed her gloves. Review of the facility policy titled Handwashing/Hand Hygiene dated August 2024 revealed the facility considered hand hygiene the primary means to prevent the spread of infections. Staff should perform hand hygiene in the the following situations: before and after direct contact with residents, before and after handling an invasive device, before handling clean or soiled dressings, gauze pads, before moving from a contaminated body site to a clean body site during resident care, after contact with objects in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings.Review of the facility policy titled Enhanced Barrier Precautions undated revealed staff should don a gown and gloves during high (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact resident care activities for residents on EBP. This deficiency represents noncompliance investigated under Complaint Number 2808594.