

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: 365425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Newark Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the medical record, review of the ambulatory wound clinic notes, review of the pharmacy delivery slips, review of the facility policy, review of facility emails, and interviews with staff, the facility failed to ensure a comprehensive initial wound assessment for a new wound was completed, wound treatments were completed as ordered, the physician was notified of absent dressings, wound interventions were in place and initiated timely, the wound was adequately assessed for appropriate wound staging, imaging services were completed as ordered, and infection control was maintained during wound care, to prevent the in-house development and/or worsening of a pressure ulcer to the coccyx of Resident #01. Actual harm occurred on 02/21/26 when Resident #01, who was assessed to be at risk for developing pressure ulcers, had moderately impaired cognition, was dependent on staff for all activities of daily living including turning and repositioning, and was non-ambulatory, was identified to have a blister to the left buttock. The wound was initially identified as Moisture Associated Skin Damage (MASD) to the coccyx and deteriorated to Stage IV pressure ulcer (full thickness tissue loss with exposed underlying muscles, tendons and bones). This affected one resident (Resident #01) of three reviewed for pressure ulcers. The facility census was 114. Findings Include: Review of the medical record revealed Resident #01 was admitted to the facility on [DATE]. Diagnoses included fractured right neck of the femur, antineoplastic chemotherapy pancytopenia, dementia, atherosclerotic heart disease, depression, cardiac defibrillator, ischemic cardiomyopathy, hypertension, edema, malignant neoplasm of the anus and urinary incontinence. Review of the Braden score dated 01/07/26 revealed Resident #01 was assessed to be at low risk for pressure injuries. Review of the physician's orders revealed Resident #01 had an order for a pressure-reducing mattress and cushion dated 01/20/26. Review of the nursing note dated 02/21/26 at 10:02 A.M. (recorded as a late entry on 02/22/26 at 5:37 P.M.) revealed the nursing assistant informed the nurse that Resident #01 had a new skin sore on her buttocks and upon observation the left buttock had a blister-like area that was starting to open. The area was cleaned with normal saline (NS) and zinc was applied. The residents' power of attorney (POA) and physician were notified. There was no further assessment or measurement of the wound. Review of the Telehealth Visit note by Physician #400 dated 02/22/26 at 5:34 P.M. revealed Resident #01 had a blister-like skin issue to the left buttock, it was cleaned with NS and zinc was applied. Review of the February 2026 physician's orders and Treatment Administration Record (TAR) from 02/19/26 through 02/24/26 revealed Resident #01 did not have a treatment ordered or administered (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	for the left buttock. Review of the nursing note dated 02/25/26 at 10:40 A.M. (recorded as a late entry on 02/26/26 at 10:47 A.M.) revealed during wound rounds the Nurse Practitioner noted Moisture Associated Skin Damage (MASD) to the coccyx of Resident #01. A new order was received to cleanse the area with wound cleanser, assess and treat with zinc oxide cream twice daily. The resident's POA was notified. Review of the Wound Skin Note dated 02/25/26 at 8:50 P.M. revealed Resident #01 had MASD to the coccyx which measured 1.3 centimeters (cm) by 1.0 cm by 0.1 in depth. It was house acquired, and the peri-wound was pink. The resident's POA was notified. Review of the physician's orders dated 02/25/26 revealed Resident #01 had a new order for wound care to the MASD to the coccyx, cleanse with NS or wound cleaner, pat dry, apply zinc oxide every shift. Review of the Braden Scale dated 02/27/26 revealed Resident #01 was at moderate risk for pressure injuries. Review of the nursing note dated 02/27/26 at 1:19 P.M. revealed Resident #01 had a new skin alteration noted to the coccyx. A new order was obtained. The resident resided on the dementia unit and attempted to toilet herself independently. Resident #01 needed assistance with toileting and showering but did not always tell or allow staff to assist her with her toileting needs. Staff were to continue to encourage the resident to allow staff to assist, a new order in place and implemented per order. Would continue to monitor area for improvement until resolved. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #01 had moderately impaired cognition, was dependent upon staff for all activities of daily living, was incontinent with bladder and bowel, and had no pressure injuries or MASD. Review of the Wound Skin note dated 03/05/26 at 12:16 P.M. revealed Resident #01 had MASD to the coccyx which measured 1.0 cm by 1.0 cm by 0.1 cm in depth. It was house acquired, and the peri-wound was pink. The resident's POA was notified. Review of the Wound Skin note dated 03/10/26 at 12:16 P.M. revealed Resident #01 had an unstageable (full thickness skin loss but the depth was unknown due to the wound bed being covered with dead tissue) pressure ulcer to the coccyx which measured 1.27 cm by 2.3 cm by 0.0 cm in depth with 90 percent slough (dead tissue). There was a moderate amount of serosanguineous drainage. It was house acquired and the residents POA was notified. Review of the physician's order dated 03/10/26 revealed Resident #01 had an order to clean the coccyx with NS, apply Medi-honey and calcium alginate, and cover with a foam dressing every day shift and as needed if soiled/dislodged. Review of the physician's order dated 03/11/26 revealed Resident #01 had an order for a low air loss mattress for wound care and a Roho cushion (air filled medical cushion to help distribute body weight evenly to promote proper blood flow) in the wheelchair at all times. Review of the Administration note dated 03/11/26 at 7:42 P.M. revealed the nurse was informed by the Former Director of Nursing #215 to hold off on the air mattress for safety reasons. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the email dated 03/12/26 at 10:48 A.M. revealed Central Supply #302 was asking Purchasing Director #401 and Therapy Director #500 if they could order a couple Roho cushions because they had a resident who needed one. Review of the email dated 03/12/26 at 3:39 P.M. from Purchasing Director #401 to Central Supply #302 and Therapy Director #500 revealed the Roho Cushion had been ordered. Review of the physician's order dated 03/16/26 revealed Resident #01 had a new order for Pro-Heal protein supplement 30 milliliters twice daily for wound healing. Review of the Wound Skin note dated 03/17/26 at 6:26 P.M. revealed Resident #01 had an unstageable pressure ulcer to the coccyx which measured 1.27 cm by 1.63 cm by 0.0 in depth with 80 percent slough. There was a moderate amount of serosanguineous drainage. The resident's pain was one out of 10 (on a scale of zero to 10, zero being no pain and 10 being the worst). It noted it was in-house acquired and to continue with the same treatment order. The resident's POA was notified. Review of the Wound Skin note dated 03/24/26 at 4:02 P.M. revealed Resident #01 had a Stage III pressure ulcer (a full thickness skin loss with visible subcutaneous fat but no exposed muscle, tendon or bone) to the coccyx which measured 2.13 cm by 1.73 cm by 1.0 cm in depth with 70 percent slough. There was a moderate amount of serosanguineous drainage. It was house acquired. The resident's pain was zero out of 10, the POA was notified and there were new treatment orders. Review of the physician's orders dated 03/24/26 revealed Resident #01 had a new order to cleanse the wound with NS or wound cleanser, apply Santyl (topical debridement) to the wound bed, and cover with calcium alginate and superabsorbent dressing to the Stage III pressure ulcer daily and as needed until resolved. Review of the Wound Skin note dated 03/31/26 at 11:51 A.M. revealed Resident #01 had an unchanged Stage III pressure ulcer to the coccyx which measured 2.6 cm by 1.5 cm by 1.6 cm in depth with 70 percent slough. There was a small amount of serosanguineous drainage and there were no odors or signs of infection. It was house acquired. The resident's pain was zero out of 10, the POA was notified and there were no new treatment orders. Review of the documented weights in Point Click Care revealed on 04/06/26, which was the last weight documented for Resident #01, revealed she weighed 112 pounds. Review of the Wound Skin note dated 04/07/26 at 5:37 P.M. revealed Resident #01 had an unchanged Stage III pressure ulcer to the coccyx which measured 2.72 cm by 2.08 cm by 1.1 in depth with 70 percent slough. There was tunneling at the 11 to 12 o'clock location at 2.0 cm in depth. There was a moderate amount of serosanguineous drainage. It was house acquired. The residents' pain was zero out of 10, the POA was notified and there was new treatment orders added. Review of the physician's orders dated 04/07/26 revealed Resident #01 had a new order to cleanse the coccyx with NS, apply Santyl to the wound bed, pack with Dakin's half strength moistened gauze and cover with a superabsorbent dressing daily and as needed until resolved. Review of the April Medication Administration Record (MAR) revealed Resident #01 was being treated with Oxycodone 5.0 milligrams every six hours as needed for breakthrough pain on 04/10/26 at 5:58 A.M. for a pain level of six out of 10 which was effective and on 04/10/26 at 11:59 A.M. for a pain (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Pharmacy delivery Slip dated 05/27/26 at 2:00 A.M. revealed Resident #01 received 10 Aquacel AG advantage dressings. Review of the Concern Form dated 06/01/26 revealed the Family of Resident #01 had another concern regarding her treatment not being completed on 05/31/26 (Sunday) and 06/01/26 (Monday). The action taken was her dressing was to be completed Monday, Wednesday, and Friday. It noted the treatment needed completed as soon as possible, to have the Nurse Practitioner round on the resident, and the nurse to assess the wound. Review of the nursing note dated 06/01/26 at 10:20 A.M. revealed the nurse was asked to assess Resident #01's current wound treatment by the POA due to her concerns that the dressing had not been changed on 05/31/26 or 06/01/26. The nurse explained to the POA that the current treatment order was only to be completed on Monday, Wednesday, and Friday. The POA informed the nurse, who was new to the facility, the resident was also followed by an outside wound physician and request the outside wound physician be called due to the increase wound drainage and odor. The wound nurse was notified and would update the physician regarding the POA's concerns of increased drainage and odor. There was no further evidence of documentation related to the drainage, odor, or physician notification/response. Review of the Wound Skin note dated 06/02/26 at 2:00 P.M. revealed the Stage III coccyx community-acquired pressure ulcer measured 5.0 cm by 3.0 cm by 1.5 cm in depth. There was tunneling at the 10 to 2 o'clock location at 1.5 cm in depth with 10 percent slough. There was a small amount of serosanguineous drainage, no odor, and the wound was documented as unchanged. The residents' pain was zero out of 10. The resident was seen by the wound clinic and was to continue current treatment orders. The resident's POA was notified. Review of the ambulatory wound clinic note (which the facility did not have in the medical record, obtained by the hospital on [DATE]) dated 06/03/26 revealed Resident #01 presented to the hospital last month for a, what the family thought, was an infected decubitus ulcer and the resident was started on an antibiotic at that time. The family stated she had the ulcer for approximately four months and the dressing changes had resulted in cleaning of the wound well, but they were still reporting significant pain, and the resident was not being turned or not allowing herself to be turned on a regular basis. It noted that this would result in poor to no healing and worsening of the wound. The resident had a Stage IV sacral pressure ulcer that was cleaned up quite a bit with the Santyl with better tissue at the base, there was no surrounding cellulitis or erythema, and a moderate amount of serosanguineous drainage without odor. The plan was to start Durafiber with foam as the Santyl was not needed anymore. Once again, the family was told that if the rotation schedule was not employed, the wound would not get better, and her pain would not improve either as it was causing ischemia (restricted blood flow) to the tissues. The resident was ordered to be on an every two-hour rotation schedule, offloading, nutritional supplements and to follow up in one month. Review of the wound after-visit summary dated 06/03/26 revealed Resident #01 was to start sulfamethoxazole-trimethoprim (Bactrim DS) (antibiotic) one tablet twice daily for 14 days, follow up in month, a treatment was ordered to clean with NS, Durafiber AG, foam dressing, and Allevyn three times a week, offloading, and every two-hour rotation. Review of the nursing note dated 06/03/26 revealed Resident #01 returned from the wound clinic appointment. A wound assessment completed, indicating a worsening wound with tunneling. New orders received to discontinue the Santyl and to start Resident #01 on Bactrim DS for 14 days. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Newark Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Physician refused to change the frequency of the dressing change and wished to remain on a three-times a week schedule using the same material except the Santyl, the physician stated they need to let the treatment do its job. The POA was aware of the treatment frequency and was agreeable. Resident #01 was to return in one month in which the POA was aware. Review of the physician's orders dated 06/03/26 revealed Resident #01 had an order for Bactrim DS Oral Tablet 800-160 MG one tablet twice daily for 14 days for wound infection, cleanse the coccyx with NS or wound cleanser, pat dry, apply Aquacel AG, and cover with superabsorbent dressing three times weekly and as needed until resolved, resident only up for one to two hours at a time, and turn and reposition ever two to three hours. Observation on 06/12/26 at 8:30 A.M. revealed the air mattress for Resident #01 was set for a resident who weighed 220 pounds. Observation of wound care for Resident #1 on 06/12/26 at 1:25 P.M. with Licensed Practical Nurse #100 and Assistant Director of Nursing (ADON) #220 revealed the ADON placed the clean dressing supplies directly on the bedside table without cleaning/sanitizing the bedside table prior to laying them down, she retrieved four paper towels from the bathroom dispenser and placed them on the bedside table for a barrier however she never placed the dressing on the barrier. LPN #100 cleaned the wound with no concerns, however when she went to initial the foam dressing, the ADON moved LPN #100's isolation gown out of the way, LPN #100 grabbed the black marker out of her right front pocket, wrote the date on the foam dressing, placed the black marker on to the bedside table, proceeded to pick up the piece of Aquacel AG with her now contaminated gloved hands and started to tear the dressing in half until the surveyor intervened. An interview at 1:43 P.M. with LPN #100 verified she had touched the contaminated black marker prior to touching the clean Aquacel AG and she should have washed her hands and changed her gloves before she touched the dressing. An interview at 1:45 P.M. with the ADON revealed the facility did not have any more Aquacel AG so they would have to call the physician for a new order. She further verified LPN #100 had contaminated the clean field when she touched the soiled black marker however she stated she had cleaned the bedside table prior to them coming into the room to do the dressing change. On 06/12/26 at 2:40 P.M. an interview and observation with Registered Nurse (RN) #110 revealed the air mattress for Resident #01 was set for a resident who weighed 220 pounds and Resident #01 did not weigh 220 pounds. RN #110 stated she would find out why it was set at 220 pounds. On 06/12/26 at 3:10 P.M. an interview with ADON #220 revealed the facility had issues receiving the Roho cushion for Resident #01. She verified it was ordered on 03/11/26 but it had not been received until after 04/27/26 due to issues with nonpayment of bills. She indicated she did not know when the facility actually received the Roho cushion. She verified the nursing staff was incorrectly charting Resident #01 had the Roho cushion to her wheelchair from 03/11/26 until around 04/27/26 when she did not have it. She also stated they removed the low air loss mattress to the bed on 03/11/26 due to fear of her falling out of bed, but she verified Resident #01 had never fallen out of bed due to an air mattress and they had not put any other new interventions in its place. She verified there was no order for a treatment from 02/21/26 until 02/24/26. She indicated she believed the imaging ordered for 04/10/26 of the sacrum and coccyx was completed at the hospital but verified there was no documented evidence that the imaging was completed as ordered. On 06/12/26 at 4:30 P.M. an interview with the Administrator verified there was no order for a wet to dry dressing and no physician notification that the dressing was not available from 05/21/26 to (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Newark Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	05/24/26. On 06/13/26 at 1:30 P.M. a review with the Interim Director of Nursing (IDON) of all the concerns related to Resident #01 wounds revealed she verified there was no assessment and no order written on 02/21/26 when the blister-like area was found to the left buttock, there was no other interventions were put into place upon finding the wound, the wound declined from 03/05/26 to 03/10/25 and went from MASD to unstageable on 03/10/26, she verified the air mattress should not have been discontinued on 03/11/26 without another intervention put into place, she verified the facility did not obtain the Roho cushion for Resident #01 in a timely manner, and the wound had further declined from 03/17/26 to 03/24/26 and should not have been changed from an		

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NAME OF PROVIDER OR SUPPLIER Newark Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 75 McMillen Drive Newark, OH 43055	
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility water temperature logs, review of the facility policy, and interview, the facility failed to maintain appropriate water temperatures on the hallway with rooms including Room Numbers 100, 101, 102, 103, 104, 105, 107, 473, 474, 475, and 476. This affected four residents (#22, #38, #57, and #61) out of four residents reviewed for environment, and had the potential to affect all 10 residents (#3, #9, #12 #22, #36, #38, #49, #57, #61, and #87) on the 100 and 400 hallway. Findings Include: Review of the weekly tap water temperature logs from 03/07/26 through 06/13/26 revealed no temperature or room number were documented it just indicated the temperatures were checked and were within normal limits. Observation on 06/13/26 at 8:50 A.M. revealed the public restrooms tap water appeared to be hot and the surveyor was unable to hold hands under the water safely. Observation on 06/13/26 from 9:00 A.M. through 9:10 A.M. of water temperatures on the 100 and 400 hallway, which was one continuous hallway, revealed room [ROOM NUMBER] (Resident #57's room) revealed the tap water temperature was 138 degrees Fahrenheit (F), the tap water temperature of room [ROOM NUMBER] (Resident #22's room) was 140 degrees F, the tap water temperature in room [ROOM NUMBER] (Resident #61's room) was 140 degrees F, and the tap water temperature in room [ROOM NUMBER] (Resident #38's room) was 138 degrees F. Observations on 06/13/26 at 9:20 A.M. of tap water temperatures, with Maintenance #200 using the facility thermometer, revealed the tap water temperature in room [ROOM NUMBER] (Resident #61's room) was 140 degrees F and the tap water temperature of room [ROOM NUMBER] (Resident #22's room) was 140 degrees F. An interview at this time with Maintenance #200 revealed the whole hall would be that temperature because it was on the same loop. He stated the boiler was set at 120 degrees F, so he did not understand why the water in the rooms were higher than the boiler temperature. He stated would have to look into what was going on. On 06/13/26 at 10:55 A.M. an interview with the Administrator revealed the facility had not had any resident burns. On 06/13/26 at 12:36 P.M. an interview with the Administrator revealed the tap water temperature logs did not indicate the actual water temperatures or what rooms were tested they just indicated the water was within normal range. She verified she was unable to indicate what the last temperatures were reading for Rooms 103, 105, 107 and 474. Review of the facility policy titled, Water Temperatures, Safety of, dated 12/09 revealed tap water in the facility should be kept within a temperature range to prevent scalding of residents. Step 1 of the policy indicated water heaters that serviced resident rooms, bathrooms, common areas and shower/tub areas should be set to a temperature of no more than 120 degrees F or the maximum allowable temperature per state regulations. Step 2 of the policy indicated the maintenance staff was responsible for checking thermostats and temperature control in the facility and recording these checks in the maintenance log. Step 3 of the policy indicated the maintenance staff should conduct periodic tap water temperatures and record the water temperature in a safety log. This deficiency is based on an incidental finding discovered during the course of this complaint investigation.		