

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: 365425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
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.			
(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 - 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 observation, record review, facility policy review, and interviews, the facility failed to ensure an adequate stock of controlled substances were on-hand to adequately treat pain. This affected two residents, Resident #46 and Resident #65. Actual Harm occurred when the facility failed to ensure scheduled pain medication was reordered timely and available for Resident #65 and Resident #46. Resident #65's pain medication was not documented as administered on 08/09/25, 08/10/25, 08/11/25, and 08/12/25 leading to Resident #65 reporting pain, rating the pain a ten on a one to ten scale, with 10 being the worst pain ever experienced. Resident #65's pain medication was not documented as administered and on 08/11/25 at 10:43 A.M. and 12:01 P.M., Resident #46 reported constant and intense pain in the legs where an amputation had been performed. Resident #46 rated his pain at a level of 1000 out of ten on the numeric pain scale and complained he could not get out of bed. Resident #46 resident reported the nurse was aware of his severe pain and was working on obtaining his ordered medication. This affected two (Residents #46 and #65) of four residents reviewed for pain. The facility census was 105. Findings include: 1. Review of the medical record for Resident #65 revealed an initial admission date of 05/05/18 and a re-entry date of 11/01/18. Medical diagnoses included rheumatoid arthritis, osteoarthritis, and right temporomandibular joint disorder. Review of the undated care plan for Resident #65 revealed the resident had complaints of pain related to inconsistent bowel pattern, rheumatoid arthritis, osteoarthritis, temporomandibular joint dysfunction and gout with multiple comorbidities. Interventions noted for the care plan included administering medications as ordered by the physician and to notify the physician if the current pain medication regimen was ineffective. Review of the physician orders for Resident #65 revealed an order dated 04/11/24 for Methadone (opioid) Hydrochloride (HCL), 10 milligram (mg) tablet, give one tablet in the morning for pain management. Resident #65 had an order dated 09/07/24 for Oxycodone HCL 10 mg, give one tablet by mouth every four hours as needed for moderate to severe pain. Review of Resident #65's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making. Resident #65 had impairment to the bilateral lower extremities and was receiving opioid pain medication daily. Review of the Medication Administration Record (MAR) for August 2025 for Resident #65 revealed the scheduled Methadone HCL 10 mg tablet was not administered on 08/09/25, 08/10/25, 08/11/25, or 08/12/25. This medication was not administered again until 08/13/25, where Resident #65 reported a pain level of a 10 on a one to ten scale. Review of a nursing progress note dated 08/11/25 at 1:37 P.M. revealed Resident #65 was out of her ordered Methadone 10 mg tablets. The pharmacy was called and stated the resident needed a new (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain a clean kitchen environment. This had the potential to affect all 105 residents residing in the facility who received meals from the facility kitchen. The facility census was 105. Findings include: An observation made on 08/11/25 at 9:00 A.M. during the initial kitchen tour revealed a large, uncovered commercial floor stand mixer with the mixing bowl in place. The mixer bowl was observed to have dust and small pieces of paper in the bottom of the bowl. Further observation revealed a free standing reach-in refrigerator in the prep area with the right hand side door handle covered with a sticky substance and a dried white substance (similar to dried batter) which dripped from above the door handle to below the door handle on the outside of the left door. Observation of the gas-powered cooktop revealed a thick, black, crusted, and greasy substance on the flat surfaces around the burners with a dried yellow substance observed on top of the thick, black, crusted, and greasy substance between the front edge of the cooktop and the front right burner. In an interview on 08/11/25 at 9:30 A.M., Dietary Director #195 verified the large commercial floor stand mixer was uncovered and the mixer bowl had dust and small pieces of paper in the bottom of the bowl. Dietary Director #195 also verified free standing reach-in refrigerator in the prep area had the right hand side door handle covered with a sticky substance and a dried white substance (similar to dried batter) which dripped from above the door handle to below the door handle on the outside of the left door. Dietary Director #195 further verified the gas powered cooktop had a thick, black, crusted, and greasy substance on the flat surfaces around the burners with a dried yellow substance observed on top of the thick, black, crusted, and greasy substance between the front edge of the cooktop and the front right burner.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on medical record review, controlled substance log review, staff interview, and facility policy review, the facility failed to ensure residents were free from significant medication errors related to controlled medications. This affected six residents (#1, #3, #36, #62, #93, and #108) of seven residents reviewed for medication administration. The facility census was 105. Findings include: 1. Review of the medical record for Resident #1 revealed an initial admission date of 10/06/21 with a re-entry date of 03/09/25. Diagnoses included stage three chronic kidney disease, chronic obstructive pulmonary disease, and peripheral vascular disease. Review of Resident #1's physician order dated 03/09/25 revealed an order for Oxycodone (narcotic pain medication) 5 milligram (mg) tablet, give two tablets by mouth every eight hours for pain. Review of the Controlled Drug Receipt/Record/Disposition form revealed on 08/12/25, Resident #1 received the scheduled pain medication at 5:16 A.M. and again at 9:00 P.M. Resident #1's 2:00 P.M. dose had not been administered or signed out on the log. On 08/16/25, Resident #1 was noted to receive the scheduled pain medication at 6:00 A.M. and again at 2:30 P.M. but had not received the 9:00 P.M. dose. Interview on 8/18/2025 at 10:00 A.M. with Licensed Practical Nurse (LPN) #403 confirmed Resident #1 was scheduled to receive Oxycodone every eight hours or three times a day and on a few of the noted days, the resident only received this medication twice. 2. Review of the medical record for Resident #36 revealed an admission date of 11/25/22. Diagnoses included cervical disc disorder, generalized anxiety, and mucopurulent chronic bronchitis. Review of Resident #36's physician order dated 12/13/23 revealed an order for Norco (a narcotic pain medication containing a combination of Hydrocodone and acetaminophen) oral tablet 5-325 mg, give one tablet by mouth three times a day for pain. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #36's Norco medication revealed on 08/12/25, this medication was recorded as being administered at 10:22 A.M., 2:26 P.M., 4:00 P.M., and 9:57 P.M. Interview on 08/18/25 at 10:00 A.M. with LPN #403 confirmed Resident #36 was supposed to receive the scheduled pain medication three times a day and received it four times on 08/12/25. 3. Review of the medical record for Resident #62 revealed an initial admission date of 08/07/24 and a re-entry date of 10/05/24. Diagnoses included alcoholic cirrhosis of the liver, osteoarthritis of the left hip, and hypertension. Review of Resident #62's physician order dated 06/25/25 revealed an order for Oxycodone HCL 5 mg tablet, give one tablet my mouth in the morning for moderate to severe pain. Review of the Controlled Drug Receipt/Record/Disposition form revealed Resident #62's scheduled pain medication was administered twice on 07/23/25, at 9:50 A.M. and at 8:35 P.M. This pain medication was also administered twice on 07/27/25 at 8:00 A.M. and again at 8:30 A.M. Interview on 08/18/25 at 10:00 A.M. with LPN #403 confirmed Resident #62 was supposed to get his (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled pain medication one time a day in the morning and actually received two doses of this medication on 07/23/25 and 07/27/25. 4. Review of the medical record for Resident #93 revealed an initial admission date of 01/18/24 and a re-entry date of 06/04/25. Diagnosis included chronic obstructive pulmonary disease, chronic kidney disease, and respiratory failure. Review of Resident #93's physician order dated 06/04/25 revealed an order for Oxycodone HCL 20 mg tablet, give one tablet by mouth every 6 hours for chronic pain. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #93's pain medication revealed this medication was administered five times on 08/10/25 at 5:10 A.M., 8:00 A.M. 10:10 A.M., 12:00 P.M. and 6:00 P.M. On 08/12/25, only three doses were administered instead of the scheduled four at 5:30 A.M., 4:00 P.M. and 11:00 P.M. Continued review revealed Resident #93 only received three doses of this medication again on 08/14/25, at 12:11 P.M., 5:25 P.M. and 11:00 P.M. On 08/17/25, Resident #93 was noted to only receive three doses of this medication at 6:23 A.M., 2:08 P.M. and 11:17 P.M. Interview on 08/18/25 at 10:00 A.M. with LPN #403 confirmed Resident #93 received one dose too many on 08/10/25 and one dose less than what was ordered on 08/12/25, 08/14/25, and again on 08/17/25. 5. Review of the medical record for Resident #108 revealed an admission date of 08/04/25. Diagnoses included dementia, bipolar disorder, anxiety disorder, and insomnia. Review of Resident #108's physician order dated 08/04/25 revealed an order for Lorazepam (a controlled anti-anxiety medication) 1 mg tablet, give one tablet by mouth every eight hours for anxiety. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #108 revealed this medication was administered only two times on 08/09/25 at 5:22 A.M. and at 10:10 P.M. instead of three times that day. Interview on 08/18/2025 at 10:00 A.M. with LPN #403 confirmed a medication that was scheduled to be administered every eight hours would equal out to three times a day and that Resident #108 did not receive the correct amount of medication on 08/09/25. 6. Review of the medical record for Resident #3 revealed an admission date of 07/25/22 with diagnoses of chronic pulmonary edema, chronic obstructive pulmonary disease, acute diastolic heart failure, chronic respiratory failure with hypoxia, metabolic encephalopathy, chronic pain syndrome, rheumatoid arthritis, and a personal history of diabetic foot ulcer. Review of the care plan dated 01/19/24 revealed Resident #3 was at risk for pain related to chronic pain syndrome, rheumatoid arthritis, and comorbidities. Interventions include administering analgesia as per orders, anticipating need for pain relief, calling for assistance when in pain, evaluating the effectiveness of pain interventions, and monitoring for side effects pertaining to pain medication. Review of Resident #3's physician orders revealed an order dated 03/09/25 revealed Oxycodone HCL extended-release (ER) tablet 10 mg, give one tablet by mouth two times a day related to chronic pain (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	syndrome. Continued review revealed an additional physician order dated 03/12/25 for Oxycodone HCl oral tablet 10 mg, give one tablet by mouth every six hours for pain. Review of Resident #3's Minimum Data Set (MDS) 3.0 annual assessment completed 07/13/25 revealed the resident was cognitively intact, received opioid medications, and had a scheduled pain medication regimen. Review of Resident #3's Medication Administration Record (MAR) from 07/01/25 through 07/31/25 revealed OxyContin (narcotic pain medication) 10 mg was scheduled to be administered at 7:00 A.M. and 7:00 P.M., and on 07/29/25 the medication was marked as given. Additionally, Oxycodone 10 mg was scheduled for administration on 07/29/25 at 5:00 A.M., 11:00 A.M., 5:00 P.M., and 11:00 P.M. On 07/29/25, an extra administration of Oxycodone 10 mg was not documented. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #3 dated 07/23/25 through 07/30/25 revealed on 07/29/25 at 10:00 A.M. and again at 12:00 P.M., the resident was administered Oxycodone 10 mg tablets. The form recorded five administrations of Oxycodone 10 mg tablets were given on 07/29/25, where the resident was scheduled to receive four doses per day. Review of the Controlled Drug Receipt/Record/Disposition form for Resident #3 dated 07/25/25 through 08/08/25 for Resident #3 revealed only one dose of OxyContin on 07/29/25 at 11:50 P.M. was logged and was noted as administered late. The form did not include indication that the scheduled 7:00 A.M. dose was administered on 07/29/25. Review of Resident #3's progress notes dated 07/29/25 revealed no documentation pertaining to a medication error. Additionally, there was no notification of physician notification of the error. Review of a medication error without harm report dated 08/18/25 revealed Resident #3 was noted to have received Oxycodone 10 mg on 07/29/25 at 10:00 A.M. instead of the scheduled OxyContin. An agency nurse was noted to have signed off the medication in the narcotic book. Resident #3 had no adverse effects. The report noted an unnamed Nurse Practitioner was notified. The medication error was recorded as being discussed with the resident. Interview on 08/13/25 at 11:39 A.M. with Resident #3 revealed concerns pertaining to the medication error. The resident stated an error had occurred a couple of weeks ago and that during the incident, she could not stay awake and believed she was overdosed on her pain medication. Interview on 08/18/25 at 1:18 P.M. with the Regional Director of Clinical Services (RDCS) #901 confirmed two doses of Oxycodone were given on 07/29/25 at 10:00 A.M. and 12:00 P.M. RDCS #901 confirmed the extra administration of Oxycodone was not documented on the MAR and prior to the surveyor's request for additional information, management was unaware of the documented medication error; therefore, an incident report was not completed on the day of the incident or around the event. Interview on 08/19/25 at 5:24 P.M. with Licensed Practical Nurse (LPN) #404 confirmed she worked with Resident #3 on 07/29/25. She denied knowledge of any medication error that day. However, she confirmed, based on the signature on the Controlled Drug Receipt/Record/Disposition form the resident's Oxycodone, that she administered the medication. LPN #404 denied notifying the physician, stating she was unaware that a medication error had occurred. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy Accidents and Incidents - Investigating and Reporting dated 07/2017 revealed all accidents or incidents involving residents occurring on facility premises shall be investigated and reported to the administrator, additionally the nurse supervisor/charge nurse/supervisor shall promptly initiate and document investigation of the accident or incident. Review of the policy Controlled Substances revealed access to controlled medications remain locked at all times, and access is recorded. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on the premises. Upon administration, the nurse administering the medication is responsible for recording the name of the resident receiving the medication, the name, strength, and dose of the medication, time of administration, quantity remaining, and a signature of the nurse administering the medication. This deficiency represents noncompliance investigated under Complaint Number 1263770 (OH00165823).		

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to have resident funds available to the residents on the weekend. This affected one resident (#15) and had the potential to affect all residents with funds managed by the facility. The facility census was 105. Findings include: Review of Resident #15's medical record revealed an admission date of 03/10/23 and diagnoses including but not limited to diabetes, schizophrenia, other seizures, depression, bipolar disorder current episode mixed, severe, with psychotic features, anxiety disorder, hyperlipidemia, and hypertension. Review of Resident #15's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition. Review of Resident #15's facility-managed funds account records dated June 2025 to August 2025 revealed there were no receipts for money released to Resident #15 from his facility-managed account on any weekend days. Interview on 08/12/25 at 10:00 A.M. with Resident #15 revealed he was unable to get money from his facility-managed account on the weekend because no one was in the facility's office on Saturdays or Sundays. Interview on 08/20/2025 at 2:01 P.M. with Business Office Manager (BOM) #102 confirmed no one is available in the facility to get funds for the residents on Saturdays or Sundays. BOM #102 further stated that the residents who frequently accessed their facility managed funds were aware that no one was available to access the facility-managed funds on Saturdays or Sundays and normally get their money for the weekend on Fridays.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Preadmission Screening and Resident Review (PASARR) assessments were accurately completed. This affected three residents (#7, #13, and #15) out of five residents reviewed for accurate PASARR assessments. The facility census was 105. Findings include: 1. Review of the medical record for Resident #13 revealed an admission date of 02/18/2025. Diagnosis included major depressive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, and seizures. Review of the PASARR for Resident #13 dated 01/31/25 revealed under Section E: Indication of Serious Mental Illness, that no mental disorders had been noted. Review of Resident #13's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08 out of 15 indicating moderately impaired cognition for daily decision-making abilities. Resident #13 was noted to display disorganized thinking and inattention. Review of the undated plan of care revealed Resident #13 was at risk for exhibiting behaviors related to depression, bipolar, anxiety and PTSD behaviors due to behavioral diagnoses. Interventions included to attempt non-pharmacological interventions such as one-on-one care, change in position or scenery, offer food and/or fluids, redirect, provide activity of choice, toileting, monitor behaviors, and a psychological or counseling consult as needed for PTSD triggers as they arise. Interview on 08/13/25 at 9:18 A.M. with Licensed Social Worker (LSW) #217 confirmed Resident #13's PASSAR was not properly completed to reflect her current diagnoses, and a new updated one should have been completed to accurately reflect her diagnoses. 2. Review of the medical record for Resident #7 revealed an admission date of 09/20/24 with diagnoses of schizophrenia (01/09/19), major depressive disorder (01/09/19), anxiety (07/26/19), panic disorder (04/15/20), other specific personality disorders (09/20/24), delusional disorder (10/23/24). Review of the care plan dated 10/03/24 revealed Resident #7 has potential for mood swings and behavioral issues related to anxiety, panic disorder, personality disorder and depression. Interventions included to administer medications as ordered, attempt non-pharmacological interventions, encourage socialization, and to follow up with psychiatry and medical director for medication review. Review of psychiatry skill nursing encounter dated 07/29/25 revealed the current problem list included diagnoses of anxiety, schizophrenia, panic disorder, major depressive disorder, insomnia, and personality disorder. Review of Resident #7's PASARR dated 07/30/25 revealed diagnoses of mental disorders listed were mood disorder, delusional disorder, panic or other severe anxiety disorder, and personality disorder. Interview on 08/14/25 at 9:20 A.M. with LSW #217 confirmed that the PASARR completed on 07/30/25 did not reflect Resident #7's mental health diagnoses. Complete list of diagnoses included schizophrenia (01/09/19), major depressive disorder (01/09/19), anxiety (07/26/19), panic disorder (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(04/15/20), other specific personality disorders (09/20/24), delusional disorder (10/23/24). LSW #217 confirmed schizophrenia was omitted from the PASARR on 07/30/25. LSW #217 confirmed these diagnoses should have been submitted promptly to the Ohio Department of Aging through an updated PASARR in accordance with federal regulation. 3. Review of Resident #15's medical record revealed an admission date of 03/10/23 and diagnoses including but not limited to diabetes, schizophrenia, other seizures, depression, bipolar disorder current episode mixed, severe, with psychotic features, anxiety disorder, hyperlipidemia, and hypertension. Review of Resident #15's MDS 3.0 assessment dated [DATE] revealed a BIMS score of 15 indicating the resident had intact cognition. Further review of Resident #15's MDS revealed the resident was independent with his activities of daily living and was receiving antipsychotic, antianxiety, antidepressant, and opioid medications. Review of Resident #15's most recent PASARR dated 02/06/25 revealed section E question number six In the past six months has the individual been prescribed any psychotropic medications? was marked as no. Review of Resident #15's physician's orders for February 2025 revealed an order dated 02/01/24 for Olanzapine (an antipsychotic medication) 10 milligrams (mg) at bedtime, An order dated 01/29/25 for Remeron (an antidepressant medication) 15 mg at bedtime, and an order dated 02/01/24 for Venlafaxine (an antidepressant medication). In an interview on 08/14/25 at 9:30 A.M. with LSW #217 confirmed section E question number six of Resident #15's PASARR dated 02/06/25 In the past six months has the individual been prescribed any psychotropic medications? was marked as no. LSW #217 confirmed Resident #15 was on psychotropic medications at the time the PASARR was completed.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a baseline care plan for Resident #2 within 48 hours of admission as required. This affected one resident (#2) of four residents reviewed for dementia care. The facility census was 105. Findings include: Review of Resident #2's medical record revealed an admission date of 06/04/25 and diagnoses including but not limited to dementia, frontotemporal neurocognitive disorder, atrial fibrillation, hypertension, major depressive disorder, hyperlipidemia, and osteoarthritis. Review of Resident #2's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) due to being rarely or never understood, had behaviors of physical symptoms directed at others for four to six days during the assessment window, verbal symptoms directed toward others for one to three days during the assessment window, and rejection of care for four to six days during the assessment window. Further review of the MDS revealed Resident #2 required partial to moderate assistance with eating and mobility, and required substantial assistance for all other activities of daily living (ADLs), was always incontinent of bladder and bowel, and had one venous wound. Resident #2 received antipsychotic, antidepressant, hypnotic, anticoagulant, and anticonvulsant medications during the review period. Review of Resident #2's care plans revealed all care plan problems were dated as being initiated on or after 06/10/25. There was no evidence that a baseline plan of care had been initiated within 48 hours of admission. In an interview on 08/19/2025 at 2:55 P.M. Licensed Practical Nurse (LPN) Unit Manager #215 confirmed all of Resident #2's care plan problems were dated as being initiated on or after 06/10/25 more than 48 hours after the resident was admitted on [DATE].		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the care plan included comprehensive psychosocial interventions to address identified behaviors. This affected one resident (#64) out of thirty residents reviewed for care planning. The facility census was 105. Findings include: Review of the medical record for Resident #64 revealed an admission date of 05/30/25 with diagnoses including depression, anxiety disorder, hypertension, and insomnia. Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #64 was cognitively intact and has no mood or behavioral concerns. Review of the care plan dated 07/14/25 revealed the resident was known to make inappropriate and sexual comments to staff. Interventions included one-on-one supervision, every 15-minute and 30-minute checks as needed for safety of both this resident and others, referral to psych as needed, and staff monitoring for any inappropriate behaviors. Interview on 08/18/25 at 3:52 P.M. with Resident #64 revealed he wanted to grow a relationship with a cognitively impaired resident located within the facility. Resident #64 was unhappy the facility had forbidden him from seeing this resident in person and was forced to have supervised visits or visits behind glass walls. Interview on 08/19/25 at 8:19 A.M. with the Administrator confirmed Resident #64 voiced a desire to grow a relationship with a cognitively impaired resident, Resident #107. They informed Resident #107's Power of Attorney (POA) who requested the resident have no contact with Resident #64. The facility agreed, stating they wanted Resident #64 to cool off. The Administrator was unsure if Resident #64 was seeing psych services at this time but believed it could be beneficial. The Administrator reported that staff are well aware that Resident #64 was to stay away from Resident #107. The Administrator shared Resident #64 had become obsessed with Resident #107, and staff are diligent to ensure that during the entire friendship, interactions were only under supervised visits. The facility will continue to keep Resident #64 and Resident #107 separate until Resident #107's POA agreed otherwise, at which time the situation would be revisited. The Administrator confirmed these current concerns were not noted on the resident's care plan. This deficiency represents non-compliance investigated under Complaint number 2592657.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, this facility failed to ensure care plans had been revised to accurately reflect enhanced barrier precautions and fluid restrictions had been discontinued. This affected two residents (#24 and #66) of 30 residents reviewed for care planning. The facility census was 105. Findings include: 1. Review of the medical record for Resident #24 revealed an initial admission date of 08/09/24 and a re-entry date of 07/11/25. Diagnoses included chronic systolic heart failure, peripheral vascular disease, and atrial fibrillation. Review of Resident #24's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Review of the undated care plan revealed Resident #24 required enhanced barrier precautions for infection prevention. Observations completed on 08/11/25 at 10:00 A.M. and again on 08/19/25 at 11:00 A.M. revealed Resident #24 did not have enhanced barrier precautions in place per the care plan. Interview on 08/14/25 at 12:47 P.M. with Regional Director of Clinical Services (RDCS) #997 revealed Resident #24 previously had a wound area that required enhanced barrier precautions which had since healed. RDCS #997 stated nursing staff must have forgotten to discontinue this in the care plan, but it was no longer required. 2. Review of the medical record for Resident #66 revealed an admission date of 06/03/14. Diagnosis included alcohol induced persisting dementia, hypertension, and hypokalemia. Review of the care plan dated 02/17/2021 revealed Resident #66 was at risk for fluid volume deficit related to cognitive impairment and fluid restriction. Interventions included to maintain a fluid restriction of 1800 milliliters (ml) in a 24-hour period. Review of Resident #66's MDS 3.0 quarterly assessment dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderately impaired cognition for daily decision-making abilities. Review of Resident #66's physician orders for August 2025 revealed no active fluid restrictions orders. Interview on 08/14/2025 at 12:27 P.M. with RDCS #997 confirmed Resident #66 did not have an order for a fluid restriction, but it was still in the care plan, most likely it was something that was missed and just needed to be removed.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, and staff interview, the facility failed to ensure fall interventions were in place. This affected two residents (#1 and #43) of five residents reviewed for fall safety. The facility census was 105. Findings include: 1. Review of the medical record for Resident #1 revealed an initial admission date of 10/06/21 and a re-entry date of 03/09/25. Diagnoses included peripheral vascular disease, embolism and thrombosis of deep veins of the lower extremities, and unsteadiness on feet. Review of the physician orders for Resident #1 dated 02/25/25 revealed an order for the resident's bed to be in the lowest position when occupied. Review of the care plan dated 03/10/25 for Resident #1 revealed this resident was at risk for falls related to medication use, decrease mobility, non-ambulatory, and obesity comorbidities. Fall interventions included to be sure the call light is in reach, bed in lower position when occupied, and to follow facility fall protocol. Review of Resident #1's 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 decision-making abilities. Resident #1 was noted to experience impairment to both lower extremities and was dependent on staff for bed mobility. Observations made on 08/11/25 at 9:30 A.M., on 08/14/25 at 11:00 A.M., and 2:30 P.M., on 08/19/25 at 3:00 P.M., and again on 08/20/25 at 10:40 A.M., revealed Resident #1's in bed at the time of each observation. During each observation, the bed was not in the lowest position. Interview on 08/18/2025 at 3:19 P.M. with Licensed Practical Nurse (LPN) #403 confirmed Resident #1 had an order for his bed to be in the lowest position when occupied and per current observation, Resident #1's bed was not in the lowest position. 2. Review of the medical record for Resident #43 revealed an initial admission date of 04/05/24 and a re-entry date of 07/27/24. Diagnoses included a pathological fracture of the left femur, vascular dementia, muscle weakness, and difficulty walking. Review of Resident #43's quarterly MDS 3.0 assessment dated [DATE] revealed a BIMS score of 09 out of 15 indicating a severely impaired cognition for daily decision-making abilities. Review of the undated care plan revealed Resident #43 was at risk for falls due to a cerebral vascular accident with hemiplegia to the left side, use of psychotropic medications, cognitive status, and vitamin d deficiency. Interventions include to place a reminder sign in the resident's room to remind him to call for assistance. Observations completed on 08/12/25 at 3:10 P.M. and again on 08/20/25 at 9:40 A.M. revealed no signs were posted in Resident #43's room to remind him to call for assistance. Interview on 08/20/25 at 10:00 A.M. with Registered Nurse (RN) #999 confirmed there was not a sign posted in Resident #43's room to remind him to call for assistance as per order and fall interventions. Review of the policy Managing Falls and Fall Risk, revised 03/2021 revealed the staff will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of a fall. This deficiency represents noncompliance investigated under Complaint Number 2582471.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure nutritional supplements were implemented upon dietician and dialysis center recommendations for Resident #6. Additionally, the facility failed to implement interventions to prevent further weight loss for Resident #35. The affected two residents (#6 and #35) out of five residents reviewed for nutrition. The facility census was 105. Findings include: 1. Review of the medical record for Resident #6 revealed an admission date of 02/25/22 with diagnoses including end-stage renal disease, type two diabetes mellitus, gastroesophageal reflux disease, moderate protein-calorie malnutrition, and hypo-osmolality with hyponatremia. Review of the care plan dated 09/28/23 revealed Resident #6 was at risk for altered nutrition and hydration related to body mass index (BMI), therapeutic diet, and weight changes with fluid balance. The resident was noted to refuse facility weights, had a history of hospice care, and was known to refuse supplements. Interventions included administering medications as ordered, honoring food preferences, monitoring and recording meal intake, monitoring for changes in nutritional status, providing a liberalized renal diet with regular consistency, and coordinating care with the dialysis center and Registered Dietitian (RD) as appropriate. Review of Resident #6's physician orders dated 09/11/24 included an order for a house nutritional supplement of 120 milliliters (ml) twice daily. Review of Resident #6's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed the resident was moderately cognitively impaired, had a diagnosis of malnutrition, and was on a physician-prescribed weight-loss regimen. Review of a progress note dated 11/27/24 revealed documentation of a dialysis center recommendation to change the house nutritional supplement to Nepro (a nutritional supplement designed for individuals with kidney conditions) eight ounces (oz) daily. Review of a Nutritional Registered Dietitian/Dietetic Technician Registered (RD/DTR) assessment completed on 01/01/25 revealed the resident was recorded to be overweight, receiving the house supplement twice daily, and undergoing hemodialysis treatments three times per week. Review of a progress note dated 08/18/25 revealed a recommendation was made to change Resident #6's house supplement from 120 ml twice daily to Nepro 120 mL twice daily due to laboratory results and dialysis status. Interview on 08/20/25 with Registered Dietitian (RD) #922 confirmed that the 11/27/24 dialysis recommendation was not documented as having been discussed with the resident or addressed as recommended. RD #922 additionally confirmed that the 08/18/25 recommendation to change the house nutritional supplement to Nepro 120 ml twice daily had not been implemented. 2. Review of Resident #35's medical record revealed an admission date of 04/18/16, a re-entry date of 03/06/17 and a recent return from the hospital date of 08/01/25. Further review revealed diagnoses including but not limited to unspecified psychosis, delusional disorders, Parkinson's disease, major depressive disorder, paranoid personality disorder, unspecified low back pain, cardiac murmur, osteoporosis, anxiety, hyperlipidemia, and hypertension. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #35's care plan dated 09/12/23 revealed the resident was at risk for weight loss, with a goal of weight maintenance without significant change thought the next review and interventions including monitor the resident for unplanned weight loss, report weight loss to the physician and the dietician and the dietician was to evaluate and make recommendations as needed. Review of Resident #35's MDS quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven, indicating the resident had impaired cognition. Further review of the MDS revealed Resident #35 was independent with her activities of daily living (ADLs), was occasionally incontinent of urine, had not had any weight loss at the time of the MDS, and was working with occupational therapy. Review of Resident #35's physicians orders dated 08/01/25 revealed the resident was to receive a regular diet with a mechanical soft texture and regular consistency liquids. Review of Resident #35's medical record revealed that on 07/10/25, the resident weighed 148.2 pounds (lbs) and on 08/01/25, the resident weighed 135 lbs which was a -8.91% weight loss. Further review of Resident #35's medical record revealed on 08/01/25, the resident weighed 135 lbs. On 08/05/25, the resident weighed 130.9 lbs. On 08/13/25, the resident weighed 134.5 lbs. On 08/15/25, the resident weighed 134.8 lbs. On 08/16/25, the resident weighed 133.5 lbs, and on 08/17/25, the resident weighed 133.4 lbs. Review of Resident #35's medical record revealed a nutrition assessment dated [DATE] indicating the resident had a significant weight loss. Review of Resident #35's progress notes revealed a nutrition progress note dated 08/07/25 at 1:45 P.M. that stated Resident #35's weight status was noted and there was a possible scale inaccuracy per the facility Interdisciplinary Team (IDT). The facility medical director was made aware of weight discrepancy and plan for reweigh. Further review of Resident #35's progress notes revealed a note dated 08/14/25 that stated the Certified Nurse Practitioner (CNP) was notified of Resident #35's weight change with a new order received to weigh the resident daily for the next three days. Review of Resident #35's meal intakes for August 2025 revealed the resident was consuming 75 to 100 percent of her meals. In an interview on 08/20/2025 at 12:54 P.M., RD #922 confirmed nutritional interventions were not started for Resident #35 when her significant weight loss was identified on 08/04/25. Review of the policy Weight Management Guidelines, undated, revealed that as part of the risk review process for weight loss the facility was to intervene according to best practice guidelines.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #79's medical record included a physician order for hemodialysis treatments. This affected one resident (#79) of two residents reviewed for dialysis. The facility census was 105. Findings include: Review of Resident #79's medical record revealed an admission date of 02/26/25 and diagnoses including but not limited to orthopedic aftercare following surgical amputation, end stage renal disease, congestive heart failure, diabetes, left above the knee amputation, dependence on renal dialysis, hypertension, and anxiety disorder. Review of Resident #79's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident had intact cognition. Resident #79's MDS indicated the resident had rejected care one to three days in the MDS review window, the resident was independent with eating and was dependent for all other activities of daily living, was always incontinent of bladder and bowel. Resident #79 was recorded to have received dialysis treatments. Review of Resident #79's care plan revealed a care plan dated 02/28/25 for the potential for complications related to end stage renal disease requiring dialysis. Further review revealed Resident #79 was to have dialysis on Mondays, Wednesdays and Fridays, facility staff were to observe the resident's shunt daily for infection and bleeding and to monitor the resident for complications related to dialysis such as air embolism, fluid overload, weak irregular pulse, bleeding and infection. Review of Resident #79's physicians orders did not reveal an order for the resident to receive hemodialysis treatments. Resident #79's record additionally did not contain any orders related to the hemodialysis access site or any monitoring for signs or symptoms of complications. In an interview on 08/20/2025 at 9:05 A.M. Licensed Practical Nurse (LPN) Unit Manager #215 confirmed there was not an order for hemodialysis in Resident #35's physicians orders. In an interview on 08/20/2025 at 10:43 A.M., the Administrator stated the facility did not have dialysis policy they just follow the federal regulations.		

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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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure the physician visited residents at the required frequency. This affected one resident (#2) of four residents sampled for dementia care. The facility census was 105. Findings include: Review of Resident #2's medical record revealed an admission date of 06/04/25 and diagnoses including but not limited to dementia, frontotemporal neurocognitive disorder, atrial fibrillation, hypertension, major depressive disorder, hyperlipidemia, and osteoarthritis. Review of Resident #2's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS) assessment due to being rarely or never understood, had behaviors of physical symptoms directed at others for four to six days during the assessment window, verbal symptoms directed toward others for one to three days during the assessment window, and rejection of care for four to six days during the assessment window. Further review of the MDS revealed Resident #2 required partial to moderate assistance with eating and mobility, and required substantial assistance for all other activities of daily living (ADLs), was always incontinent of bladder and bowel, and had one venous wound. Resident #2 received antipsychotic, antidepressant, hypnotic, anticoagulant, and anticonvulsant medications. Review of Resident #2's progress notes revealed no notes from the resident's primary care physician. In an interview on 08/20/25 at 9:05 A.M. Licensed Practical Nurse (LPN) Unit Manager #215 confirmed there were no progress notes from Resident #2's primary care physician contained in Resident #2's medical record to indicate the resident had been seen by a physician. In an interview on 08/20/25 at 9:47 A.M., the Administrator stated she expected physician visits to occur as outlined in the federal regulations. Review of the Physicians Service Policy, revised 04/2013, revealed physician visits and frequency of visits were to be provided in accordance with current federal regulations.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, interview, and facility policy review, the facility failed to ensure pharmacy recommendations that were addressed by the physician were implemented in a timely manner. This affected one resident (#43) of five residents reviewed for unnecessary medications. The facility census was 105. Findings include: Review of the medical record for Resident #43 revealed an initial admission date of 04/05/24 and a re-entry date of 07/27/24. Diagnoses included vascular dementia with moderate mood disturbances, mood disorder, and anxiety. Review of physician orders for Resident #43 revealed an order dated 05/16/25 for Lorazepam (also known as Ativan, an antianxiety medication) 0.5 milligram (mg) tablet, give 0.5 mg by mouth every six hours as needed for anxiety and restlessness. Review of the pharmacy recommendation dated 05/19/25 revealed the resident was presently prescribed Lorazepam (Ativan) 0.5 mg by mouth every 6 hours as needed for anxiety. The form included a recommendation to please document duration and rationale for extended therapy of the as-needed order. The recommendation was noted to be reviewed by the physician on 05/28/25 with the recommendation for this as-needed medication to have a duration of 14 days. Review of Resident #43's physician orders revealed no evidence of the as-needed Lorazepam medication was changed to reflect the duration of 14 days after the physician responded to the recommendation. Continued review revealed the Lorazepam ended up being discontinued on 06/16/25. Interview on 08/19/2025 12:23 PM with Licensed Practical Nurse (LPN) #215 revealed the facility received the pharmacy recommendation for Resident #43's Lorazepam order on 05/16/25 and it was reviewed by the physician on 05/28/25. LPN #215 verified the physician marked this medication for a duration of 14 days and then it was to be discontinued but it was not. When the pharmacy came back in the following month for the next review, they noticed the Lorazepam medication was still active with no duration noted, so that medication was discontinued at that time. Review of the facility policy titled, Consultant Pharmacist Services, dated 06/21/2017 revealed the consultant pharmacist will conduct a medication regimen review for facility residents at least monthly or as outlined per the pharmacy services agreement. The consultant pharmacist or designee will provide written reports to the facility with findings and recommendations related to the review.		

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

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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, hospice records, staff interview, and facility policy review, the facility failed to ensure hospice records were available for review to allow for effective collaboration between the facility and the hospice provider. This affected one resident (#43) of one resident reviewed for hospice care. The facility census was 105. Findings include: Review of the medical record for Resident #43 revealed an initial admission date of 04/05/25 and a re-entry date of 07/27/24. Diagnoses included vascular dementia, cerebral atherosclerosis, disorders of the bone density and structure, and hypertension. Review of Resident #43's Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 09 out of 15 indicating severely impaired cognition for daily decision-making abilities. Interview on 08/19/25 at 12:49 P.M. with a hospice staff member revealed Resident #43 was planned to receive Certified Nursing Assistant (CNA) services three times per week, nursing care weekly, and a social services visit monthly. All staff who visit Resident #43 are to fill out a summary of the care provided after returning to the office and this will either be faxed or emailed over to the facility. Interview with 08/19/25 10:00 A.M. with Registered Nurse (RN) #243 revealed hospice notes are located at the nurse's station in a binder. Observation of the binder revealed only a sign in log was located in this binder. No hospice notes or care notes were available. RN #243 stated that she believed the unit manager may have Resident #43's hospice notes in her office. A request was made on 08/19/25 for Resident #43's hospice notes for review which was not provided until later that same day. Each received document was noted to be printed on 08/19/25, which was the day the notes were requested. Interview with Licensed Practical Nurse (LPN) #215 confirmed the documents were not available at the facility upon request and Hospice had to be contacted so the documents could be forwarded to the facility. Review of the facility policy titled, Hospice Program, dated 07/2017 revealed the facility would designate a staff member to ensure that the long-term care facility communicates with the hospice medical director, the residents attending physician and other practitioners participating in the provision of care to the resident as needed. This deficiency represents noncompliance investigated under Complaint Number 1263770 (OH00165823).		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure Resident #75's wound and living space were free from pests. This affected one resident (#75) of six residents sampled for wounds. The facility census was 105. Findings include: Review of Resident #75's medical record revealed an admission date of 01/31/05 and diagnoses including malignant neoplasm of head and face, squamous cell carcinoma, autistic disorder, diabetes, anxiety disorder, peripheral vascular disease, hypertension, acquired absence of right leg below the knee, and non-pressure chronic ulcer of other part of left lower leg with other specified severity. Review of Resident #75's Minimum Data Set (MDS) significant change in status assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13 indicating the resident was cognitively intact and had no recorded behaviors. Further review revealed Resident #75 required set up assistance for eating and was dependent on staff for all other activities of daily living. Resident #75 was assessed to be always incontinent of bladder, frequently incontinent of bowel, and was receiving hospice services. Resident #75 was recorded as having an unhealed diabetic ulcer. Review of Resident #75's progress notes revealed a note dated 07/17/25 at 11:33 P.M. written by Licensed Practical Nurse (LPN) Unit Manager #215 indicating she was notified of a new wound and upon assessment, debris was noted in the wound bed of the left foot. Observation on 08/11/25 at 10:40 A.M. revealed flies were observed in Resident #75's room and in the hallway outside of Resident #75's room. Observation on 08/14/25 at 11:00 A.M. revealed flies were observed in Resident #75's room on the bed. In an interview on 08/18/25 at 12:36 P.M., LPN Unit Manager #215 stated Resident #75 had chronic cellulitis of her lower left leg and foot and was being treated with an antibiotic (medication used to treat infection) and a diuretic (medication used to help decrease swelling) prior to the wound on her left foot opening on 07/17/25. A follow-up interview at 12:47 P.M. revealed LPN Unit Manager #215 stated there were also some maggots present in Resident #75's wound bed when she first observed the wound on 07/17/25. However, LPN Unit Manager #215 stated the next day Resident #75's wound bed was clean. In an interview on 08/18/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #146 revealed Resident #75's wound was found on 07/17/25 when she and CNA #125 were providing care, and the wound was observed to have some maggots in it. CNA #146 and CNA #125 reported the new area immediately to the nurse. CNA #146 stated she had not seen any other wounds with maggots in them. In an interview on 08/18/25 at 3:17 P.M., LPN #403 stated that she completed a treatment to Resident #75's left lower leg on 7/17/25 on day shift and she did not see any new area on the foot at that time. LPN #403 stated that she changed the dressing while the resident was lying in bed, and had to pick up Resident #35's leg to do the dressing and had a good view of the bottom of her foot. In an interview on 08/19/25 at 9:00 A.M., CNA #125 stated that when the open area was found on Resident #75's left foot it had a few maggots in it. CNA #125 stated she had not seen any other wounds with maggots in them. CNA #125 stated Resident #75 often had flies in her room because she would hoard food and trash and the staff had to go in and clean her room. Observation on 08/19/25 at 12:12 P.M. revealed Resident #75's dressing change was completed by LPN Unit Managers #215 and #240. The dressing to Resident #75's plantar surface wound of the left foot was completed. The wound bed was observed and appeared clean with no debris present in the wound. However, flies were noted in the room during the dressing change and the presence of the flies were confirmed by LPN Unit Managers #215 and #240. This deficiency represents noncompliance investigated under Complaint Numbers 2582471 and 2568937.		