STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365440	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Care Center	98 South 30th Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and medical record review the facility failed to ensure one, (Resident #37) received timely assistance with facial grooming. This affected one of two reviewed for activities of daily living (ADL). The facility census was 97Findings include:Review of Resident #37's medical record revealed an admission date of 02/05/26. Medical diagnoses include encounter for other orthopedic aftercare, nondisplaced intertrochanteric fracture of left femur subsequent encounter for closed fracture with routine healing, need for assistance with personal care, wedge compression fracture of unspecified lumbar vertebrae, chronic kidney disease stage III, Alzheimer's disease, and essential primary hypertension.Review of Resident 37's admission Minimum Data Set (MDS) 3.0 dated 02/11/26 revealed a Brief Interview for Mental Status (BIMS) score which was noted as not completed due to Resident #37 is rarely/never understood. Review of functional abilities note Resident #37 requires substantial/maximal assistance with personal hygiene.Review of Resident #37's bath/shower sheets revealed on 02/07/26, 02/11/26, and 02/21/26, Resident #37 was not shaved, and no reason was noted as to why this was not completed.Observation on 02/23/26 at 11:26 A.M. revealed Resident #37 to be sitting in wheelchair with long facial hair on her chin.Interview with Certified Nursing Assistant (CNA) #113 at 3:37 P.M. confirmed Resident #37 would not be able to verbalize if she wanted her facial hair to be shaved and confirmed Resident #37 did have facial hair on her chin and she would take care of it for her.The facility did not have an activities of daily living policy.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident #102 received services for her vision. This affected one, (Resident #102) of one resident viewed for communication and sensory. The facility census was 97.Findings include: Review of Resident #102's medical record revealed an admission date of 09/25/24 with diagnoses including end stage renal disease, type two diabetes mellitus, hemiplegia and hemiparesis affecting left nondominant side, major depressive disorder, anxiety disorder, and anemia.Review of Resident #102's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition and adequate vision.Review of Resident #102's Healthdrive request for service, dated 10/03/24, revealed the resident had requested to be seen by eye care.Review of Resident #102's physician order dated 11/04/25 revealed an order to be treated as needed by podiatrist, dentist, or optometrist.Review of Resident #102's plan of care on 02/25/26 revealed it did not address her vision.Interview on 02/23/26 at 11:18 A.M. with Resident #102 revealed she had blurry vision and she had not seen anyone about it since she came to the facility. She reported she had told multiple people she wanted to see the eye doctor.Interview on 02/25/26 at 2:12 P.M. and 4:32 P.M. with Social Service Designee #135 revealed when residents sign the consent for the eye doctor the form is supposed to get sent to Healthdrive and the resident will get seen by them. She verified Resident #102 had signed this consent form and had not been seen. Social Service Designee #135 reported Resident #102 had not seen the eye doctor since she admitted to the facility and would be signed up to see someone for blurry vision.The facility did not have a policy for ancillary services.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate foot care. Based on record review, observation, and interview the facility failed to provide timely podiatric care for one, (Resident #79) of two reviewed for activities of daily living (ADL). The census was 97.Findings include:Review of Resident #79 ' s medical record revealed an admission date of 11/21/25. Diagnoses include spinal stenosis lumbar region without neurogenic claudication, wedge compression fracture of T 9-T 10 (thoracic) vertebra subsequent encounter for fracture with routing healing, Type II Diabetes Mellitus with diabetic polyneuropathy, and essential primary hypertension.Review of Resident 79 ' s admission Minimum Data Set (MDS) 3.0 dated 02/05/26 revealed a Brief Interview for Mental Status (BIMS) score of seven. Review of functional abilities revealed Resident #79 required substantial/maximal assistance with putting on/taking off footwear.Review of Resident #79 ' s care plan dated 02/03/26 confirmed Resident #79 may require assistance with ADLs and may be at risk for developing complications associated with decreased ADL self-performance. Resident #79 is assisted with all ADL function bathing, transfers, toileting hygiene, foley catheter care, grooming, dressing, and oral care. Resident #79 was able feed self with set up assist, used a wheelchair for mobility needs when out of bed. Goal included all resident ADL's need will be met through the next review date. Interventions included diabetic nail care and grooming (nails, shave, hair) assistance needed and staff to anticipate needs and assist as needed.Review of Resident #79 ' s physician orders confirmed active order placed on 11/22/25 for Podiatry to evaluate feet as indicated for foot care and as needed for diabetic shoes. Further review revealed, an active order placed on 11/22/25 noting diabetic foot care: caregiver to wash, dry, and apply house stock lotion to bilateral feet checking for any skin concerns to foot/toes.Review of Resident#79's medical record revealed he had no documented progress note or evaluation from the podiatrist in his medical record. Review of the completed Podiatry appointments in the facility confirmed Resident #79 was not seen by Podiatry.Observation on 2/23/026 at 11:46 A.M. revealed Resident #79 ' s bilateral feet were exposed revealing long jagged toenails.Interview with 02/25/26 at 9:23 A.M. with the Unit Manager #46 and Assistant Director of Nursing (ADON) #50 confirmed Resident #79 ' s toenails were long and the wound nurse practitioner would trim them the current day.Interview on 02/25/26 at 12:18 P.M. with Social Services Designee #135 confirmed new admissions are advised of ancillary services.There was not an Ancillary services policy in place during the survey.

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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 obtain weekly weights for Resident #37 who was a new admission and at nutritional risk. This affected one (Resident #37) of two residents reviewed for nutrition. The census was 97.Findings include: Review of Resident #37's medical record revealed an admission date of 02/05/26. Medical diagnoses include encounter for other orthopedic aftercare, nondisplaced intertrochanteric fracture of left femur subsequent encounter for closed fracture with routine healing, need for assistance with personal care, wedge compression fracture of unspecified lumbar vertebrae, chronic kidney disease stage III, Alzheimer's disease, and essential primary hypertension.Review of Resident 37's admission Minimum Data Set (MDS) 3.0 dated 02/11/26 revealed a Brief Interview for Mental Status (BIMS) was not completed noting Resident #37 is rarely/never understood. Review of functional abilities revealed Resident #37 required partial/moderate assistance with eating. Further review revealed an admission weight of 132 pounds (lbs).Review of Resident #37's weights revealed an admission weight of 132.4 lbs on 02/06/26 and weight of 119.0 lbs on 02/23/26.Review of Resident #37's nutrition assessment dated [DATE] revealed Resident #37 was on a regular diet with regular texture. Meal intake records less than or equal to(</=) 50 percent (%) heavily assisted/fed by staff, regular diet is adequate but oral (po) is lagging. PO may improve with time and routine post-op noting to monitor.Review of Resident #37's progress note dated 02/23/26 comprised by Dietician #25 noted Resident #37 weight 119.0 lbs representative of a 13.4 lb or 10.1% weight loss since admission.Review of facility weight log for unit C revealed Resident #37 had a weight of 105.0 lbs for week one and weight of 119 for week three. Interview on 02/25/26 at 3:35 P.M. with Dietician #25 confirmed new admissions should be weighed as close to weekly as possible stating she keeps a weight log.Interview on 02/26/26 at 1:51 P.M. with Dietician #25 confirmed Resident #37 should have four weights completed at this point and has only had three completed and she was still unclear of the accuracy of the resident's documented weight.Review of the facility's policy titled, Weight Monitoring dated 02/15/24, newly admitted residents' weight will be monitored as close to weekly as possible for the initial four weeks and at least monthly thereafter. There was not a re-weigh policy in place at the time of the survey.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review the facility failed to ensure Resident #13's blood pressure medications were not administered outside of parameters. This affected one resident (#13) of five residents reviewed for unnecessary medications. The facility census was 97.Findings include: Review of Resident #13's medical record revealed an admission date of 09/03/24 with diagnoses including Type Two Diabetes Mellitus, chronic obstructive pulmonary disease, chronic heart failure, and acquired absence of right leg. Review of Resident #13's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition.Review of Resident #13's plan of care dated 09/13/24 revealed the resident had altered health maintenance related to diagnoses including atherosclerotic heart disease and hypertension. Interventions included administering medications as ordered.Review of Resident #13's physician order dated 09/12/24 revealed an order for Carvedilol tablet 3.125 milligrams (mg) two times a day for hypertension. It was to be held for Systolic blood pressure (SBP) less than 100 millimeters of Mercury (mmHg) or diastolic blood pressure (DBP) less than 80 mmHg. Review of Resident #13's physician order dated 09/16/24 revealed an order for Entresto oral Tablet 49-51 mg one tablet by mouth two times a day for cardiomyopathy. The medication was to be held for SBP less than 110 mmHg, DBP less than 60, or heart rate less than 60 beats per minute (BPM). Review of Resident #13's physician order dated 09/17/24 revealed an order for Torsemide oral tablet 20 mg two tablets by mouth one time a day related hypertension. It was to be held for SBP less than 110 mmHg, DBP less than 60 mmHg, or heart rate less than 60 BPM. Review of Resident #13's Medication Administration Record (MAR) for 02/01/26 to 02/23/26 revealed in the morning Resident #13's DBP was below 60 mmHg on 02/06/26, 02/13/26, and 02/20/26. It was below 80 mmHg on 02/02/26, 02/03/26, 02/04/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/10/26, 02/14/25, 02/15/26, 02/16/26, 02/17/26, 02/18/26, 02/19/26, 02/21/26, 02/22/26, and 02/23/26.Review of Resident #13's MAR and progress notes from 02/01/26 to 02/23/26 revealed Entresto was administered in the morning on 02/06/26, 02/13/26, and 02/20/26 outside of parameters. Torsemide was administered in the morning on 02/06/26 and 02/20/26 outside of parameters. Carvedilol was administered in the morning on all the listed dates outside of parameters. There were no notes indicating the physician was notified or the medication had been approved for administration outside of parameters.Review of Resident #13's MAR for 02/01/26 to 02/23/26 revealed in the evening Resident #13's DBP was below 60 mmHg on 02/04/25, 02/10/26, 02/14/26, 02/15/26, and 02/19/26. His DBP was below 80 mmHg, on 02/02/26, 02/03/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/11/26, 02/12/26, 02/13/26, 02/16/26, 02/18/26, 02/20/26, 02/21/26, 02/22/26, and 02/23/26.Review of Resident #13's MAR and progress notes from 02/01/26 to 02/23/26 revealed Entresto was administered in the evening on 02/04/26, 02/10/26, 02/14/26, and 02/19/26 outside of parameters. Carvedilol was administered in the evening on all listed dates outside of parameters except for 02/05/26 and 02/15/26.Interview on 02/26/26 at 7:19 A.M. with Regional Clinical Manager #87 verified the medications had not been held appropriately according to the ordered parameters. Regional Clinical Manager #87 clarified with the physician the parameters as multiple parameters may have been confusing.The facility had no medication administration policy.