STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365990	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Dawn Rehabilitation and Healthcare Center	865 East Iron Avenue Dover, OH 44622

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 22653 Based on observations, medical record review, review of fall investigations, and interviews, the facility failed to implement fall interventions for three (Residents #45, #46, and #56) of five residents reviewed for falls. The facility census was 69. Findings include: During general observations on 05/06/24 and 05/07/24, Residents #45 and #46 were observed with mats placed beside their beds, when the residents were lying down in bed. 1. Review of Resident #45's open medical record revealed diagnoses including encephalopathy, restless and agitation, vascular dementia, generalized muscle weakness, abnormal posture and cerebral infarction. Review of Resident #45's fall risk assessment dated [DATE] indicated Resident #45 had one to two falls over the prior six months. Other risk factors for falls included medication use, confusion, total incontinence, confinement to a chair, inability to independently rise to a standing position and need for hands on assistance to move from place to place. Review of care plan interventions revised on 10/20/22 revealed Resident #51 was to have a mat to the bedside as of 08/26/22. On 05/08/24 at 8:42 A.M., Resident #45 was observed lying in bed without the mat placed on the floor to the left side of the bed. The fall mat was folded and leaning against the foot of the bed. On 05/08/24 at 8:42 A.M., State tested Nursing Assistant (STNA) #170 verified the fall mat was not in place and he placed Resident #45's mat on the floor on the left side of the bed. 2. Review of Resident #46's open medical record revealed diagnoses including dementia, repeated falls, malignant neoplasm of the colon and type one diabetes mellitus with diabetic neuropathy. Review of Resident #46's fall risk assessment dated [DATE] indicated risk factors included a history of multiple falls, medication use, confusion, frequent incontinence of bowel and bladder, confinement to a chair, and need for hands on assistance to move from place to place. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365990	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Dawn Rehabilitation and Healthcare Center	865 East Iron Avenue Dover, OH 44622

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of an interdisciplinary fall/incident investigation dated 12/07/23 indicated a new intervention was implemented for a mat to bedside for safety. On 05/08/24 at 8:42 A.M., Resident #46 was observed lying on a low bed without a mat beside her bed on the right side. On 05/08/24 at 8:42 A.M. STNA #170 verified the fall mat was not in place and placed Resident #46's mat on the floor on the right side of the bed. 3. Review of Resident #56's open medical record revealed diagnoses including encephalopathy, type two diabetes mellitus, muscle wasting and atrophy and bed confinement status. A fall risk review dated 06/23/23 indicated risk factors for falls included medication use, disorientation, total incontinence, agitated behavior, inability to come to a standing position, requiring hands on assistance to move from place to place, use of assistive devices and decrease in muscle coordination. Review of Resident #56's physician orders revealed an order dated 02/02/23 for a mat to bedside. On 05/08/24 at 8:25 A.M., Resident #56 was observed lying in bed. The fall mat was under Resident #56's bed. On 05/08/24 at 8:35 A.M., STNA #150 verified the mat was under Resident #56's bed instead of beside the bed. This deficiency represents non-compliance investigated under Complaint Number OH00153104.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365990	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Dawn Rehabilitation and Healthcare Center	865 East Iron Avenue Dover, OH 44622

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. 22653 Based on observation, medical record review, policy review and interview, the facility failed to store nebulizer equipment in a sanitary manner for one (Resident #51) of three residents reviewed for use of nebulizer equipment. The facility census was 69. Findings include: Review of Resident #51's medical record revealed diagnoses including cerebral infarction, congestive heart failure, and heart disease. Review of Resident #51's medical record revealed the following orders dated 01/26/24 albuterol sulfate 0.083%: three milliliters (ml) via nebulizer every six hours as needed; and also dated 01/26/24 nebusal inhalation nebulization solution 3%: give 3 ml via nebulizer twice a day. Observations on 05/06/24 at 7:55 A.M. revealed the nebulizer mask was not stored in a bag. This was verified by State tested Nursing Assistant (STNA) #145 during the observation. Observations on 05/08/24 at 8:28 A.M. revealed Resident #51's nebulizer mask was sitting on the night stand. The machine was not running. Resident #51 indicated the mask came apart from the tubing the last time he was using the nebulizer so he removed the mask and handed it to staff who placed it on the night stand. On 05/08/24 at 8:33 A.M. STNA #150 verified the mask was not stored appropriately and liquid remained in the canister. The information was shared by STNA #150 to Licensed Practical Nurse #155. Review of the facility's Nebulizer Administration policy, revised January 2018, revealed when a treatment was complete, the nebulizer should be turned off and the equipment disassembled and stored in a plastic bag. This deficiency represents non-compliance investigated under Complaint Number OH00153104.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365990	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Dawn Rehabilitation and Healthcare Center	865 East Iron Avenue Dover, OH 44622

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 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. 22653 Based on observations and interview, the facility failed to ensure the environment was maintained in a safe and sanitary manner. This had the potential to affect all residents on 100 hall (Residents #1, #2, #3, #4, #5, #6, #7, and #8) and one (Resident #41) of three residents observed for incontinence care. The facility census was 69. Findings include: 1. During tour of the facility on 05/06/24 between 4:22 A.M. and 4:55 A.M., a towel and bath blanket were observed on the floor in the 100 hall bathroom. A bath blanket was observed on the floor in the 100 hallway with safety cones. Resident #4 was observed sitting in her room, dressed in personal clothes, and coloring. During an interview on 05/06/24 during the tour after observations had been made on the 100 hall, State tested Nursing Assistant (STNA) #100 reported the bath towel on the floor in the hall was due to a leak. The towel and bath blanket in the 100 hall bathroom were from Resident #4's shower and she had not had the opportunity to remove them from the floor. No leaks were observed during multiple observations on 05/06/24 through 05/07/24. Residents of the 100 hall were identified as Residents #1, #2, #3, #4, #5, #6, #7, and #8. 2. On 05/06/24 at 8:58 A.M., STNA #145 was observed providing incontinence care to Resident #41. During the care, stool got onto the cloth pad under Resident #41 and on a pillowcase which was at Resident #41's knee level. The soiled linens were thrown onto Resident #41's floor until incontinence care was completed. During an interview on 05/07/24 at 5:08 P.M., STNA #145 verified she had thrown soiled linen on the floor while providing incontinence care to Resident #41. STNA #145 indicated she was not aware it was an infection control/sanitary issue until later in the day on 05/06/24 while providing care to another resident with a second staff member who provided instruction that it was not appropriate to throw linens on the floor. This deficiency represents non-compliance investigated under Master Complaint Number OH00153195 and Complaint Number OH00153104