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	01/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on resident interview, staff interview, Computer Aided Dispatch (CAD) call report review, Self-Reported Incident (SRI) review, and medical record review, the facility failed to ensure Resident #72 received timely care and services which resulted in the resident reaching out to an outside entity for assistance. This affected one (Resident #72) out of three residents reviewed for quality of care and treatment. The facility census was 71. Findings include: Review of Resident #72's medical record revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included diabetes mellitus type two, depression, and acquired absence of right leg below the knee. Review of Resident #72's History and Physical dated 12/23/24 revealed the resident had decreased mobility, painful movement, poor strength, and had a right below the knee amputation. The resident was noted to be alert and oriented. Review of Resident #72's care plan dated 12/23/24 revealed the resident had diabetes mellitus with interventions to monitor, document, and report to the physician signs of hyperglycemia (such as increased thirst and appetite, frequent urination, poor wound healing, dry skin, muscle cramps, abdominal pain, and stupor) and hypoglycemia (such as increased heart rate, sweating, nervousness, confusion, and lack of coordination). The care plan also revealed the resident had limited physical mobility related to weakness, intravenous (IV) medication use, history of right below the knee amputation, and other comorbidities with interventions to provide supportive care and assistance with mobility as needed. Review of Resident #72's Medicare five-day Minimum Data Set (MDS) 3.0 dated 12/27/24 revealed the resident was cognitively intact. Review of the CAD call report dated 12/26/24 at 10:08 P.M. revealed a call was made to 911 from Resident #72's room. The report revealed on 12/26/24 at 10:08 P.M. Resident #72 said he was in the rehabilitation unit and the door was closed on him and no one would help him. At 10:09 P.M. a call was made to the facility and spoke to Licensed Practical Nurse (LPN) #200 who stated she would check on Resident #72. At 11:59 P. M. Resident #72 called back in to report that he had concluded a statement internally with the facility, staff, and his state case worker. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the LPN #150's undated written witness statement revealed on 12/26/24 at 9:42 P.M. she heard a couple of loud noises and yelling between the resident (Resident #72) and the aide (CNA #100). The resident's door was closed. CNA #100 came out of the room and stated the resident was yelling and throwing things, and stated he wanted to leave because she (CNA #100) was not taking care of him. CNA #100 reported the resident stated he was going to call the cops and file charges against her. It noted that CNA #100 was about to go back into the residents room and confront him and the nurse told her to stay out and she would go talk to him as soon as he calmed down and quit throwing things. Before she could go in, the staff nurse (LPN #200) arrived and proceeded to go into Resident #72's room to find out what was going on with him. The resident stated, I asked the aide multiple times for assistance, and I didn't get any help. Review of the SRI dated 12/27/24 for neglect/mistreatment revealed Resident #72 made an allegation that CNA #100 did not answer his call light timely and stated it was neglectful. The investigation determined the allegation was unsubstantiated and evidence indicated abuse, neglect or misappropriation did not occur. The SRI investigation did not include a timeframe of when the resident began asking for staff assistance or how long it took for him to receive the assistance. Interview on 01/09/25 at 9:55 A.M. Resident #72 stated he was an amputee who was recently admitted to the facility after spending several days in the hospital. He reported on 12/26/24 around 7:30 P.M. he rang his call light and Certified Nursing Assistant (CNA) #100 answered. He stated he reported he could tell his blood sugar was getting low and asked if she could bring him a peanut butter and jelly sandwich, two sodas, and get hold of his nurse. He stated CNA #100 turned off his call light, and stated to him that they were making rounds and would get to him. An hour later he had not seen anyone and he put his call light on again. He reported CNA #100 responded and turned off his light and he requested his snack and drink again. He reported she stated she would get it when she had time. He stated he waited about another hour and turned his call light on for a third time and she came back in. He stated he told her he had still not seen the nurse, his IV antibiotic had been done for hours yet he was still connected, and he still had not received his sandwich and requested soda. He stated CNA #100 turned off the call light stating she would get to it and then she slammed the door shut while saying, Have a nice day honey. The resident stated he did not like his door shut because he had limited mobility and needed to be able to yell if he needed help. He reported he was so furious that he threw whatever he could at the door and called 911 to report that abuse of a resident was happening at the facility. He went on to say he crawled out of bed, got on his hands and knees and crawled to the door, opened it, and crawled into the hallway. He stated when he reached the hall, CNA #100 was standing there and he told her he needed the nurse. Resident #72 revealed that LPN #150 was also present and stated, I don't need to treat you, you are a combative person. Resident #72 then reported to them that the police were on their way. At that time, LPN #200 ran down the hallway asking what was going on. He reported she helped him back to his room, made sure to check his sugar, and assured him that CNA #100 would not be working with him anymore. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 01/09/24 at 11:51 A.M., CNA #100 reported she was working at the facility on 12/26/24 as an agency CNA. She reported that was the first time working on the 200 hall and she had never worked with Resident #72 before. She stated she was completing rounds around 8:00 P.M. to 8:30 P.M. when she answered Resident #72's call light and he asked for two sodas and a sandwich. She told him to give her a minute and she would get it after she completed rounds. She stated she responded to Resident #72's call light again around 10:00 P.M. and upon entering the room, she told the resident she had not forgotten about his request, but she had just not gotten around to it yet. At this time the resident became very upset and started yelling. She reported she left his room and closed the door, but left it cracked. She stated he then started throwing objects and got out of bed and crawled to the hallway. He reported to her that he called the police and that he was an amputee and needed his medications. CNA #100 confirmed she did not timely address his needs stating she was still providing activities of daily living assistance to other residents and had not had a chance to get to him yet. Phone interview on 01/09/25 at 12:38 P.M., LPN #200 revealed she was working in the back of the building when she received a phone call from the local police department. They reported Resident #72 called and reported that no one would answer his call light. She stated she then went to check on the resident and saw him ambulating down the hall on his amputated leg with CNA #100 walking away from him. She stated the resident was yelling and very agitated. The resident reported to her that the CNA #100 would come into his room and answer his call light, but kept telling him she was not his aide and she could not do anything for him, and then she shut his door. She reported she contacted management and assisted the resident with his care needs. Interview on 01/09/24 at 3:00 P.M., Clinical Manager #250 reported she got a call on 12/26/24 from LPN #200 stating that Resident #72 had called the police department and wanted to speak with management. He reported to her that he had put on his call light, requesting a sandwich and a snack, three different times and CNA #100 would not assist him with his needs. He reported to her that he then called the police department to get someone's attention and he guessed it worked. She confirmed that she completed the investigation into the incident, but did not investigate the timeline of how long and how many times Resident #72 had put on his call light or the fact that he was not given his requested snack and drink. She reported it would have been her expectation for the resident to receive his snack and drink within 10 to 15 minutes of asking. Interview on 01/09/25 at 4:00 P.M. the Administrator revealed they did not investigate into how long and how many times Resident #72 had to wait and why he did not receive his snack and drink timely. She reported the resident should not have had to wait that long for his needs to be met and her expectation would have been for him to receive his request within an hour. This deficiency represents non-compliance investigated under Complaint Number OH00161322.