

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365990	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2025
NAME OF PROVIDER OR SUPPLIER  New Dawn Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>22653</p> <p>Based on observation, review of physician orders, review of drug manufacturer information, and interview, the facility failed to ensure medications were administered in accordance with physician orders and drug manufacturer directions. Four errors were identified out of 37 opportunities for error, resulting in a 10.8% medication error rate. This affected two (Residents #30 and #51) of five residents observed having medications administered by staff.</p> <p>Findings include:</p> <p>1. On 02/18/25 at 7:40 A.M., Licensed Practical Nurse (LPN) #105 was observed administering medication to Resident #51. Among the medications administered were amlodipine (a calcium channel blocker used to treat hypertension, coronary artery disease and some angina) 10 milligrams (mg), hydralazine (vasodilator used to treat high blood pressure) 50 mg, and metoprolol succinate (beta blocker) 25 mg. The medications were administered during the process of obtaining vital signs.</p> <p>On 02/18/25 at 7:50 A.M., LPN #105 was questioned regarding if there were parameters set for administration of the medications. Resident #51's blood pressure was 125/66 and his pulse was 55. LPN #105 stated she was able to give the medications as long as the pulse was not below 55.</p> <p>Review of Resident #51's physician orders revealed all three of the medications had parameters written within the orders to hold the medications if the heart rate was less than 60.</p> <p>On 02/18/25 at 8:50 A.M., the Director of Nursing (DON) verified the orders for amlodipine, hydralazine and metoprolol succinate indicated they were to be withheld if the heart rate was less than 60.</p> <p>Review of the facility's Administering Medications policy (not dated) indicated medications must be administered in accordance with prescribed orders.</p> <p>2. On 02/18/25 between 7:55 A.M. and 8:05 A.M., LPN #110 was observed preparing and administering medication to Resident #30. While preparing to administer Lantus, LPN #110 verified there was no date indicating when the Lantus vial was opened/first accessed. The Lantus was delivered on 01/17/25. LPN #110 proceeded to draw up 30 units of the Lantus U-100 into a syringe and administered it into Resident #30's right arm. After removing the syringe, LPN #110 rubbed the injection site.</p> <p>(continued on next page)</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 02/18/25 at 8:02 A.M., LPN #110 verified she rubbed the injection site after administration of the insulin, stating she always did so.</p> <p>Review of the facility's Administering Medications policy (not dated) indicated when opening a multi-dose container, the date opened shall be recorded on the container.</p> <p>Review of Lantus manufacturer information revealed vial were to be discarded after 28 days, even if there was still insulin left in it. Instructions indicated the injection site was not to be rubbed.</p> <p>On 02/18/25 at 8:50 A.M., the Director of Nursing (DON) verified when insulin was opened it should be dated so staff could determine whether to keep using it. Manufacturer information regarding instructions not to rub the injection site was also shared with/shown to the DON who acknowledged what the instructions stated.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00162246 and Complaint Number OH00161999.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22653</p> <p>Based on medical record review, review of consultant reports, review of hospital records, and interview, the facility failed to write/transcribe orders resulting in a resident receiving ongoing treatment with an anti-neoplastic medication beyond ordered duration. This affected one (Resident #69) of three residents reviewed for medication use.</p> <p>Findings include:</p> <p>Review of Resident #69's closed medical record revealed an admitted [DATE]. Diagnoses included pleural effusion, pneumonia, difficulty walking, abnormal posture, generalized muscle weakness, essential hypertension, hyperlipidemia, atrial fibrillation, sick sinus syndrome, vitamin D deficiency, hypothyroidism, moderate protein-calorie malnutrition, presence of a cardiac pacemaker, metabolic encephalopathy, non-rheumatic aortic stenosis, congestive heart failure, gastrointestinal hemorrhage and hematemesis (vomiting blood).</p> <p>A social service progress note dated 12/27/24 at 11:15 A.M. indicated a call was received from Resident #69's daughter who accompanied Resident #69 to an orthopedic appointment. The note indicated Resident #69 had been ordered a new medication (not named) at his hematology appointment the prior week. The medication was sent to out-patient pharmacy and Resident #69's daughter was to pick it up and take it to the facility. The daughter indicated she and the hematologist believed the decline in Resident #69's condition might be due to the leukemia and were hopeful the new medication would offer some reprieve to weakness/debility.</p> <p>On 12/27/24, an order was written it was okay to administer home medication of Gleevec (anti-neoplastic).</p> <p>A social service progress note dated 12/27/24 at 4:25 P.M. indicated medication was received and given to a licensed practical nurse for administration beginning 12/28/24.</p> <p>An order was written for imatinib mesylate (Gleevec) 400 milligrams (mg) to be administered every day starting 12/28/24.</p> <p>A nursing note dated 01/14/25 at 5:04 P.M. indicated Resident #69 had blood in his mouth twice during the shift. No sores were observed. The physician and responsible party were updated.</p> <p>A nursing note dated 01/15/25 at 9:39 A.M. indicated the hematology office was notified due to Resident #69 coughing up blood the previous night. The physician was aware and gave orders to call the hematology/oncology consultant due to Resident #69 being on a new chemotherapy medication called imatinib mesylate (Gleevec). The nurse left a message requesting a nurse call the facility.</p> <p>A nursing note dated 01/15/25 at 11:28 A.M. indicated a nurse returned her call and stated the imatinib mesylate (Gleevec) was to be held until 01/30/25 and a stat CBC (complete blood count laboratory test) was to be obtained. The nurse reported the physician at the hematology/oncology center said the facility could send Resident #69 to the emergency room (ER). The responsible party was notified and wished to have Resident #69 sent to the ER.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A nursing note dated 01/15/2025 at 11:48 A.M. revealed Resident #69 had another episode of coughing up bright red blood. Resident #69 was going to the ER and the ambulance had been contacted. A subsequent nursing note at 12:01 P.M. indicated the ambulance was present to transport Resident #69 to the ER.</p> <p>A nursing note dated 01/15/25 at 10:54 P.M. indicated the hospital reported Resident #69 was being admitted for bilateral pleural effusion and Covid-19.</p> <p>Resident #69 returned to the facility on [DATE] at 5:00 P.M.</p> <p>Review of the hospital discharge paperwork revealed Resident #69 was admitted for a mouth bleed and found to have a nosebleed secondary to cancer medication. Other active problems/diagnoses included bilateral pleural effusion, COVID-19, and gastrointestinal melena (black tarry stool as a result of bleeding in the upper gastrointestinal tract). Instructions were provided to discard old medication lists and use the new list provided to update all health care providers and retail pharmacies. Instructions revealed an order to stop taking imatinib (Gleevec).</p> <p>Review of Resident #69's January 2025 Medication Administration Record (MAR) revealed no documentation indicating the order for imatinib was placed on hold per instructions provided on 01/15/25 in accordance with the nursing note. There was no documentation of imatinib being discontinued per the hospital discharge instructions dated 01/18/25. There was no documentation located indicating the attending physician ordered the imatinib to be restarted/continued upon Resident #69 re-entering the facility. The MAR revealed staff resumed administering the imatinib on 01/20/25 and continued its administration through 01/30/25.</p> <p>Laboratory results from 01/21/25 revealed a low red blood count (RBC) of 2.59 (reference range of 4.2-6.0 m/UI), low hemoglobin of 8 (13-17 g/dL), low hematocrit of 24.7 (39-51%) and a platelet count of 154 (reference range of 150-400 k/uL).</p> <p>Laboratory results from 01/24/25 revealed a low RBC of 2.7, a low hemoglobin of 8.3, a low hematocrit of 26.2 and a platelet count of 161.</p> <p>Review of office visit notes for hematology/oncology consultants dated 01/30/25 indicated Resident #69 started having worsening shortness of breath the night of 01/29/25 and worsening confusion. Resident #69 was started on oxygen via nasal cannula but was still feeling very short of breath and was very weak. Resident #69 was having periorbital edema as well as swelling in the legs and arms. Lab results included a RBC of 2.45, hemoglobin level of 7.7, hematocrit of 24.6 and platelet count of 57 which was verified by repeat analysis. Resident #69 was started on Gleevec on 12/19/24 but developed cough and hemoptysis (discharge of blood or blood stained mucus through the mouth). Resident #69 had been sent to the ER for further evaluation and found to have COVID 19 infection. Resident #69 had been admitted to the hospital and Gleevec was held. The Gleevec was to be held until a follow up with the hematology/oncology appointment on 01/30/25 but it was restarted upon discharge. The CBC obtained on 01/20/25 showed a significant decrease in hemoglobin and platelets were quite low. On exam, Resident #69 had very diminished breath sounds in the right base. The report questioned a possible recurrent/progressive pleural effusion versus pneumonia secondary to the recent COVID 19 infection. Resident #69 was referred to the ER for further evaluation. The facility was contacted and informed to hold the Gleevec until the hematology/oncology consultant approved to restart the medication. If it were to be resumed it might need to be started at a reduced dose.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 02/19/25 at 8:16 A.M., interview with Resident #69's physician (Medical Doctor #120) stated he recalled being told Resident #69's daughter had Gleevec at home and wanted to know if it could be administered in the facility. MD #120 recalled approving that. However, MD #120 did not recall being informed of or seeing an order from hematology/oncology to hold the Gleevec until his next visit on 01/30/25 or being asked about the order to discontinue the Gleevec from the hospital discharge orders. MD #120 stated he would never knowingly give an order to contradict an order from a specialist regarding the use of an anti-neoplastic medication as they were more knowledgeable about that particular subject and medication. MD #120 indicated he did not have time to review all the nursing notes for every resident so he had no knowledge of the hematology/oncology giving the order to hold the Gleevec until Resident #69's visit scheduled 01/30/25 and was unaware of the hospital discharge orders to stop the administration of the Gleevec. MD #120 indicated he reviewed the administration of the Gleevec a medication error.</p> <p>On 02/20/25 at 12:50 P.M., RN #125 from the hematology/oncology office verified the continued use of Gleevec could have contributed to the low lab values obtained on 01/30/25. RN #125 verified the table with laboratory results were labs obtained on 01/30/25. The narrative part of the Impressions section #2 of the report were not the results received on 01/30/25 although it referred to laboratory tests with different values and referred to them as being obtained today. Resident #69 continued to use their services and Gleevec had not been restarted.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00162246.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>22653</p> <p>Based on medical record review, policy review and interview, the facility failed to ensure medication administration records were maintained in an accurate and complete manner for one (Resident #63) of three residents reviewed for medication administration.</p> <p>Findings include:</p> <p>Review of Resident #63's medical record revealed diagnoses including hypertension, type two diabetes mellitus with diabetic neuropathy, intervertebral disc disorders, and arthropathies of the right shoulder.</p> <p>Review of Resident #63's January 2025 Medication Administration Record (MAR) revealed no donning of the ordered lidocaine patch on 01/04/25 or 01/31/25. There was no documentation lidocaine patches were removed in accordance with physician orders on 01/14/25, 01/19/25 or 01/31/25. Resident #63 had an order for blood glucose monitoring with sliding scale insulin coverage four times a day. No results were recorded on 01/12/25 at 5:00 A.M. or on 01/19/25 and 01/30/25 at 5:00 P.M. It was unable to be determined if the sliding scale insulin should have been administered.</p> <p>The February 2025 MAR revealed no documentation of clindamycin 300 milligrams being administered on 02/17/25's second dose. Blood sugars were not recorded on 02/01/25 or 02/17/25 for the 5:00 A.M. so it was unable to be determined if sliding scale insulin should have been administered.</p> <p>On 02/18/25 at 11:48 A.M., the Director of Nursing (DON) verified the MARs were incomplete regarding administration of medication and monitoring of blood sugars to determine if sliding scale insulin needed administered. The DON verified it there was a reason the medication was not administered, the information would require documentation.</p> <p>Review of the facility's Administering Medication policy (not dated) indicated the individual administering the medication was required to document the administration in the MAR.</p> <p>This deficiency is an incidental finding discovered during the investigation.</p>		