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	02/26/2026

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. Based on observation, medical record review and staff interview, the facility failed to ensure staff were monitoring a resident's blood pressures prior to administration of medications which had the potential to lower the resident's blood pressure. This affected one (Resident #18) of six residents observed for medication administration.Findings include:On 02/25/26 between 8:55 A.M. and 9:05 A.M., Registered Nurse (RN) #252 was observed administering medications to Resident #18. Among the medications administered were lisinopril (angiotensin-converting enzyme (ACE) inhibitor which is used to manage high blood pressure) 20 milligrams (mg) and metoprolol succinate (beta blocker used to treat high blood pressure) 50 mg. RN #252 obtained Resident #18's blood pressure after administering the blood pressure medication.During an interview on 02/25/26 at 9:09 A.M., RN #252 verified Resident #18's blood pressure should have been obtained prior to administering the medications.Further review of Resident #18's February 2026 Medication Administration Record (MAR) revealed there were no parameters set up for administration of the lisinopril or metoprolol tartrate. However, there was an area to document the blood pressure and pulse with the metoprolol tartrate administration. The MAR indicated there were five times when the metoprolol tartrate was not administered related to blood pressure readings including 90/67 the morning of 02/02/26, 93/51 the morning of 02/04/26, 95/61 on the morning of 02/05/26 and 105/90 on 02/23/26. Additional blood pressure readings of 99/63 were recorded the evening of 02/02/26 and a reading of 98/52 the morning of 02/24/26.During an interview on 02/25/26 at 1:02 P.M., the Director of Nursing (DON) stated blood pressures should ideally be monitored prior to giving medications that could affect blood pressure, especially if a resident had a history of low readings.This deficiency represents non-compliance investigated under Complaint Number 2706361.

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 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. Based on observation, record review and staff interview, the facility failed to ensure fall interventions were implemented for a resident at a high risk for falls. This affected one (Resident #64) of three residents reviewed for falls.Findings include:Review of Resident #64's medical record revealed diagnoses including dementia, repeated falls, generalized muscle weakness and difficulty walking. A plan of care initiated 11/11/22 indicated Resident #64 was at risk for falls related to weakness, co-morbidities (medical conditions that coexist alongside a primary diagnosis, affecting health, treatment, and prognosis), incontinence, and medication use. One of the interventions dated 11/16/23 included placing a dycem to wheelchair (Dycem is a non-slip material). The physician orders revealed an order dated 11/05/23 for a non-skid sheet to the wheelchair.The fall risk evaluation dated 11/04/25 revealed Resident #64 was at a high risk for falls. Risk factors included multiple falls experienced within the last six months, medication use (including diabetic medications, blood pressure medications, narcotics and psychotropic medication), memory problems, frequent incontinence, behaviors that occurred less than daily, confinement to the chair, loss of balance while standing, requiring hands-on assistance to move from place to place, use of an assistive device, and decrease in muscle coordination. The fall risk assessment revealed interventions continued to include dycem to the wheelchair. During observations and interview on 02/25/26 at 1:25 P.M., Licensed Practical Nurse (LPN) #239 verified Resident #64 was sitting in the wheelchair but there was no dycem present. This deficiency represents non-compliance investigated under Master Complaint Number 2743736 and Complaint Number 2706361.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure the resident's medical record was complete and accurate. This affected one (Resident #103) of 13 residents reviewed for medical record accuracy.Findings include: Review of Resident #103's medical record revealed an admission date of 12/24/25. Diagnoses included a non-displaced fracture of the left wrist, depression, bipolar disorder, malignant melanoma of the trunk and congestive heart failure. a. An admission nursing assessment dated [DATE] at 1:17 A.M. indicated Resident #103 was alert but confused. The section of the assessment indicating general care to be provided by nursing assistants included catheter care. Review of documentation for catheter care on the nursing assistant task bar from 12/26/25 to 01/21/25 revealed the catheter care was scheduled to be provided every shift and there was no documentation it was completed except for three days. There were three shifts (day shift on 01/16/26, 01/17/26 and 01/18/26) which were initialed. The urinary catheter was discontinued 01/22/25.During an interview on 02/25/26 at 10:24 A.M., the Director of Nursing (DON) stated there was no documentation for catheter care in December 2025 because it did not show up on aide task bar until the baseline care plan evaluation was completed and verified there were only three days it was completed in January 2026. The DON stated staff knew if residents had urinary catheters that catheter care was necessary so she believed it was a documentation issue versus failure to provide the catheter care.b. Resident #103's admission assessment revealed no skin impairment. A wound nurse practitioner note dated 12/29/25 at 8:01 P.M. indicated Resident #103's skin was intact with no open wounds. Review of skilled evaluations revealed documentation of skin concerns and dressings being dry and intact on 01/06/26, 01/12/26, 01/15/26, 01/19/26, 01/21/26 and 01/28/26. However, no skin/wound assessments were able to be located.During an interview on 02/24/26 at 10:50 A.M., Registered Nurse (RN) #252 denied Resident #103 had any wounds/dressing changes. RN #252 stated Resident #103 had a cast to her wrist but no skin impairment.During an interview on 02/24/26 at 10:53 A.M., Certified Nursing Assistant (CNA) #221 stated she was only aware of a cast on one of Resident #103's arm but no other wounds or dressings.During an interview on 02/24/26 at 11:03 A.M., the Director of Nursing (DON) reported Resident #103's skin was intact throughout her stay. The DON stated the skilled evaluations indicating there were skin concerns on 01/06/26, 01/12/26, 01/15/26, 01/19/26, 01/21/26 and 01/28/26 were incorrect.This deficiency represents non-compliance investigated under Master Complaint Number 2743736.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, medical record reviews, policy reviews, and staff interviews, the facility failed to implement appropriate infection control procedures for catheter care, wound care, and medication administration. This affected two (Residents #2 and #55) of seven residents observed during medication administration, one (Resident #67) of one resident observed for wound care, and one (Resident #25) of one resident observed for catheter care.Findings include:1. Review of Resident #55's medical record revealed diagnoses included type two diabetes mellitus and urinary tract infection (UTI). On 02/22/26, an order was received to administer meropenem one gram intravenously every eight hours for a UTI for seven days.During an observation on 02/24/26 at 9:33 A.M., Licensed Practical Nurse (LPN) #206 was observed administering the meropenem to Resident #55 through a peripherally inserted central catheter (PICC). LPN #206 did not don a gown prior to administering the meropenem. There was a sign on Resident #55's door for Enhanced Barrier Precautions (EBP).During an interview on 02/24/26 at 9:37 A.M., LPN #206 verified she had not implemented EBP because she had never been told it was required.Review of the facility's Enhanced Barrier Precautions policy (revised March 2024) revealed EBP was used as an infection prevention and control intervention to reduce the transmission of multi-drug organisms to residents. EBP employed targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions did not otherwise apply. Gloves and a gown were applied prior to performing the high contact resident care activity. Examples of high-contact resident care activities required the use of gown and gloves for EBP included device care or use including central lines. EBP was indicated for residents with indwelling medical devices regardless of colonization of multi-drug resistant organisms. 2. Review of Resident #67's medical record revealed diagnoses included peripheral vascular disease and chronic obstructive pulmonary disease. A plan of care initiated 02/06/26 revealed EBP to prevent the spread of multi-drug resistant organisms related to wounds (left toe and coccyx). One of the interventions was to wear personal protective equipment (gown and gloves) when providing care. Review of physician's orders revealed on 02/24/26, orders were written to cleanse the left third toe wound with normal saline, apply medi-honey and calcium alginate then wrap with an abdominal pad and kerlix daily and as necessary. During an observation on 02/24/26 between 2:22 P.M. and 2:28 P.M., Registered Nurse (RN) #252 was observed changing the dressing on Resident #67's wound to the lateral aspect of the third toe on the left foot. No gown was worn during the dressing change. A sign was posted on the door for EBP.During an interview on 02/24/26 at 2:32 P.M., RN #252 verified the EBP sign was related to Resident #67's wounds. RN #252 verified she had only worn gloves and had not donned a gown during the wound care. Review of the facility's Enhanced Barrier Precautions policy (revised March 2024) revealed EBP was used as an infection prevention and control intervention to reduce the transmission of multi-drug organisms to residents. EBP employed targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions did not otherwise apply. Gloves and a gown were applied prior to performing the high contact resident care activity. Examples of high-contact resident care activities required the use of gown and gloves for EBP included device care or use including central lines. EBP was indicated for residents with indwelling medical devices regardless of colonization of multi-drug resistant organisms. 3. Review of Resident #2's medical record revealed diagnoses included type two diabetes mellitus. A physician's order dated 09/20/25 indicated an accu-check (monitors blood glucose levels) was to be obtained daily.During an observation on 02/24/26 at 3:02 P.M., Licensed Practical Nurse (LPN) #219 was observed monitoring Resident #2's blood glucose level using a glucometer which was shared among residents. Upon entering Resident #2's room, LPN #219 placed the glucometer and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the container with the glucometer test strips onto Resident #2's bed. After obtaining the results and cleaning her hands, LPN #219 left the room and placed the glucometer and the container with the test strips on top of the medication cart with the items having contact with both the surface of the cart and a mouse pad sitting on top of the cart. LPN #219 then proceeded to administer medication to Resident #14 at 3:06 P.M. After leaving Resident #14's room and returning to the medication cart, no effort was made to clean or disinfect the items that had been used to test Resident #2's blood sugar levels.During an interview on 02/24/26 at 3:10 P.M., LPN #219 was asked how often glucometers were cleaned. At first, LPN #219 stated the glucometers were cleaned every shift. Then LPN #219 stated the glucometer should probably be cleaned after each use. LPN #219 verified she had placed the glucometer and the container with the test strips on Resident #2's bed then placed them on the medication cart without cleaning them.Review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy (revised July 2014) revealed reusable items were to be cleaned and disinfected or sterilized between residents.4. Review of Resident #25's medical record revealed diagnoses included congestive heart failure, vascular dementia, and obstructive and reflux uropathy (blockage in the urinary tract). An order dated 08/19/25 indicated urinary catheter care was to be provided every shift.During an observation on 02/25/26 at 10:37 A.M., Certified Nursing Assistant (CNA) #266 provided urinary catheter care for Resident #25. After providing catheter care, CNA #266 did not remove her gloves and continued to wear the same gloves to handle the call light, the bed controls, bedding, and the urinary collection bag and its cover.During an interview on 02/25/26 at 10:53 A.M., CNA #266 verified she had not removed the gloves used for catheter care prior to handling the call light, bed controls and bedding.This deficiency represents non-compliance investigated under Master Complaint Number 2743736.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the infection control log, review of guidance from National Library of Medicine, and facility policy review, the facility failed to implement their antibiotic stewardship program to promote the appropriate use of antibiotics. This affected two (Residents #2 and #24) of three residents reviewed for antibiotic use. The facility census was 67.Findings include:Review of the McGeer criteria for a urinary tract infection (IUTI) from National Library of Medicine for Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria dated October 2012 revealed the resident must meet both categories: 1. Clinical signs and symptoms which included acute dysuria or fever or leukocytosis plus one ore more of: suprapubic pain, costovertebral pain/tenderness, gross hematuria, new/increased urgency, frequency. If there is no fever/leukocytosis then two of the above symptoms must be met. The second criteria was microbiological evidence which included greater than 10 colony-forming units per milliliter (CFU/mL) in voided urine or catheter specimen.1. Review of the medical record for Resident #2 revealed an admission date of 12/13/24 and a readmission date of 09/20/25. Diagnoses included heart failure, chronic obstructive pulmonary disease, and diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 had intact cognition and was dependent on staff for activities of daily living (ADLs).Resident #2's medical record did not include any documentation of signs and symptoms for a UTI.Review of the facility's infection control log for the month of January 2026 revealed Resident #2 acquired an in-house UTI and was on an antibiotic from 01/27/26 to 02/03/26. The infection control log indicated that McGeer's criteria was met for a UTI.Interview on 02/25/26 at 11:47 A.M. with Director of Nursing (DON) verified there was no documentation of any signs or symptoms of a UTI in Resident #2's medical record. Resident #2 had lab work completed for a urinalysis ordered on 01/19/26 but did not find any documentation of signs and symptoms in Resident #2's medical record or the McGeer's assessment was completed for a UTI.2. Review of the medical record for Resident #24 revealed an admission date of 08/04/23 and a readmission date of 03/26/24. Diagnoses included chronic kidney disease, major depressive disorder, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 had intact cognition and was dependent on staff for activities of daily living (ADLs).Resident #24's medical record did not include any documentation of signs and symptoms for a UTI.Review of the facility's infection control log for the month of February 2026 revealed Resident #24 acquired an in-house UTI and was on an antibiotic from 02/01/26 to 02/06/26. The infection control log indicated the McGeer's criteria was met for a UTI.Interview on 02/25/26 at 11:47 A.M. with the Director of Nursing (DON) verified there was no documentation of any signs or symptoms of a UTI in Resident #24's medical record. The DON verified there were was no McGeer's assessment completed for the UTI.Review of the undated facility policy titled Antibiotic Stewardship Program revealed the infection control nurse and/or designee will continue infection control line listing and review facility antibiotic utilization to ensure appropriate prescribing and use of antibiotics.This deficiency represents non-compliance investigated under Master Complaint Number 2743736.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, policy review, and record review, the facility failed to maintain a call light system that was readily accessible to its residents. This affected two (Residents #19 and #30) of three residents reviewed for call light accessibility. The facility census was 67.Findings include:1. Review of Resident #19's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, schizophrenia, and major depressive disorder.Review of the care plan dated 07/09/20 revealed Resident #19 was at risk for falls related to diagnoses. Interventions included to be sure the resident's call light was within reach and have a sign in place in sight to remind Resident #19 to use her call light for assistance.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was moderately cognitively impaired and was dependent on staff for activities of daily living (ADLs).Observation and interview on 02/23/26 at 10:09 A.M. and 11:10 A.M. revealed Resident #19's call light was on the floor beside the bed. Resident #19 was sitting in her Broda chair which was placed next to bed.This was verified by Certified Nursing Assistant (CNA) #253 at 11:10 A.M. and verified the call light was not within Resident #19's reach. CNA #253 stated the loop around the call light cord was because she was blind and they put it around her wrist.2. Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, chronic kidney disease, and diabetes mellitus.Review of the care plan dated 07/16/24 revealed Resident #30 was at risk for falls related to diagnoses. Interventions included to be sure the resident's call light was within reach.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 was severely cognitively impaired and was dependent on staff for activities of daily living (ADLs).Observation on 02/24/26 at 11:05 A.M. revealed Resident #30's call light was behind her refrigerator and the resident was lying in bed. This was verified by Certified Nursing Assistant (CNA) #292 on 02/24/26 at 11:07 A.M. and verified the call light was not within Resident #30's reach.Review of the facility policy titled Answering the Call Light dated 2001 revealed that when the resident is in bed or confined to a chair, be sure that the call light is within easy reach of the resident.This was an incidental finding discovered during the course of the complaint investigation.