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	06/17/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, review of pictures, review of concern log, and interview the facility failed to ensure a safe and sanitary environment for the residents. This affected three residents (#2, #7 and #39) of 28 residents reviewed during the initial pool. Findings include: 1.Medical record review revealed Resident #39 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, Alzheimer's disease, and dementia. Review of Resident #39's quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident was not on a toileting program and was frequently incontinent of urine and was continent of bowel. Observation on 06/08/26 at 12:30 P.M. and 1:18 P.M. of 400 hallway revealed the hallway smelled of urine. Observation on 06/09/26 at 2:21 P.M., of Resident #39's room with Resident #39's daughter revealed the resident's bed sheet had a yellow ring. Resident #39's daughter smelled the area and reported the area smelled of urine. There was urine dried on the floor around the toilet. The resident's daughter cleaned one area around the toilet during observation. The resident's daughter reported the dirty sheets, urine odors, and bowel movements smeared in the bathroom by the roommate has been an ongoing concern and she had voiced concerns with staff and management. The daughter provided photo (dated and timed) evidence of bowel movements smeared on walls and toilet, urine on the floor, and dirty sheets in her mom's room that was not cleaned for 3-10 days for the last five months. The resident's daughter reported her mom had a visitor that could not stay and visit due to the odors in the room. Observation and interview on 06/10/26 at 11:38 A.M., of Resident #39's room with Certified Nurse's Aide (CNA) #74 revealed the yellow ring on the bedsheets was still there from the observation on 06/09/26 at 2:21 P.M., and there was bowel movement on the toilet seat and rails and urine on the floor. The resident's room had just been mopped due to the floor was still wet. CNA #74 confirmed the room had just been cleaned and mopped. The CNA #74 confirmed findings and reported she would have housekeeping re-clean room and she would change the bed sheet. Review of concern log revealed on 05/28/26 the ombudsman had voiced concerns to the facility regarding odors. Review of the concern form dated 05/28/26 revealed Licensed Practical Nurse (LPN) #87 received a concern from the ombudsman that reported the daughter of Resident #39 had concerns regarding urine (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smell in the room. The action taken was housekeeping to audit the room/linens, wheelchair cushion switched out and spoke to residents and no complaints and denies incontinence. The facility spoke to the daughter that was the power of attorney (POA) and not the daughter that voiced concerns and the POA had no concerns with care or the room. Interview on 06/09/26 at 1:46 PM with LPN #71 confirmed there were odors on 400 hall, and some days were worse than others. Interview on 06/10/26 at 1:56 P.M., with LPN #87 confirmed he was aware of Resident #39's daughters concerns with the bathroom and linens. The surveyor shared pictures of the bowel movements on the toilet and dirty linens with the LPN. The LPN verified pictures on bowel movements on the toilet and walls because he was the staff member the daughter reported the concern to. The LPN reported the resident roommate sometimes toilets herself and was the reason there was urine and bowel movement on the toilet, rails, and walls. The LPN reported he usually checks the resident's linens every morning, but he didn't this morning. 2. Observation and interview on 06/08/26 at 9:44 A.M., with Resident #7 revealed the bathroom was noted to have a strong urine odor. Resident denied using the bathroom and it was a private bathroom for her use only. Noted to have a bed pan that was sitting over the toilet resting on the toilet seat that was not in a bag when not in use. The resident confirmed she does use the bedpan. The wall by the door was noted to be scuffed, gouged and in the need to be repaired. Resident reported she would like to have it fixed but she could not say anything. 3. Observation on 06/10/26 at 2:00 P.M. of Resident #2's bathroom revealed several soiled briefs in a small trash can with no liner and a strong urine odor. Interview on 06/10/26 at 2:10 P.M. with anonymous staff member #58 confirmed there was an odor issue, urine odor. The staff member was unsure what was causing it, possibly the resident's soiled briefs being left in trash cans in their rooms after incontinence care or toileting. Per the anonymous staff member, some staff throw the briefs into the trash can even if there is not a liner inside. This deficiency represents non-compliance investigated under Complaint Number 3030059 .

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident, who was dependent on staff for personal care, received the assistance needed with receiving showers as scheduled. This affected one resident (#78) of four residents reviewed for activities of daily living. Findings include:Review of Resident #78's medical record revealed she was admitted to the facility on [DATE]. She was hospitalized between 04/30/26 and 05/31/26, before returning to the facility as a re-admission. Her diagnoses included reduced mobility, muscle weakness, major depressive disorder, paranoid schizophrenia, Bipolar disorder, anxiety disorder, stroke, muscle spasms, difficulty walking, dependence on a wheelchair, and repeated falls. Review of Resident #78's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not indicated to have displayed any behaviors or reject care during the seven days of the seven day assessment period. She required a substantial/ maximum assist with showers/ bathing. Review of Resident #78's active care plans revealed she had a care plan in place for an activities of daily living (ADL) self-care performance deficit related to her diagnoses of a stroke, weakness, unsteady gait, and anxiety. The interventions indicated the resident was dependent on staff for showers/ bathing. A Hoyer lift (mechanical lift used for transferring a resident from bed to chair) and staff assist were needed for transfers. Review of the shower schedule for Resident #78's hall revealed the resident was to be showered as requested. Her name was listed on the shower schedule under the day shift section but did not indicate specific days she was scheduled. She was added in each column under every day of the week as being as requested. The shower schedule indicated shower sheets were to be filled out even if the shower was refused. If they (facility staff member tracking showers) did not receive a shower sheet, they were going to assume that it was not done. Any showers that were not completed would result in a write up. Bed baths did not take the place of a shower. If a resident requests a bed bath, the aide was to notify their nurse. Review of Resident #78's bathing sheets, since her return from the hospital on [DATE] through 06/10/26, revealed she was documented as having received showers on 06/01/26 through 06/03/26. There was no documentation of a shower having been provided or offered on 06/04/26, 06/05/26, 06/06/26, 06/08/26, or on 06/09/26. Bathing sheets for 06/07/26 and 06/10/26 revealed the resident had been offered a shower on those days, but the showers were refused. Review of Resident #78's progress notes from 06/04/26 through 06/10/26 revealed no documented evidence of a shower having been offered and refused on the dates not documented showers were noted, as above. On 06/09/26 at 3:45 P.M., an interview with Resident #78 revealed she had not been showered on six different days, since she returned to the facility from the hospital. She indicated she was supposed to be getting showers daily, but was not getting them. She claimed she was not getting her showers, due to being a Hoyer lift, and it taking two people to use that. She had been told by the staff that they did not have the time to do it. On 06/10/26 at 4:21 P.M., an interview with Licensed Practical Nurse (LPN) #44 revealed Resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#78 required an extensive assist by staff for her care. She could do some things on her own, such as washing her face. She indicated the resident took showers and liked to have one every day. The other day (06/10/26) was the first time she had known the resident to refuse a shower when offered. The resident indicated on that day that she might take one later in the day, but she did not know if she ended up taking one or not. She reported the resident was to be offered a shower daily. She denied she had known the resident to refuse her showers when offered, prior to yesterday. She denied she was the nurse that worked between 06/04/26 and 06/09/26 when the resident was not documented as having received or refused a shower. On 06/10/26 at 4:28 P.M., an interview with Certified Nurse Aide (CNA) #102 revealed Resident #78 was a total assist with her care. She could only eat and drink on her own and needed help with everything else. The resident would do showers or bed baths depending on the day. Before going down hill, the resident took showers every day and was scheduled to receive them every day. The staff would ask her daily if she wanted a shower. The resident would take her showers, when offered, and she liked taking them. She did not have any knowledge as to why the resident was not documented as having been provided a shower between 06/04/26 and 06/09/26. She did recall on 06/07/26 the resident was yelling out that she wanted a bed bath and she believed her co-worker had completed the bed bath as requested. She indicated some staff may look at the shower schedule and see that the resident was to receive a shower as requested and may leave it up to the resident to request without offering one to her. With how the resident was upon her return to the facility on [DATE], you would have to ask the resident if she wanted a shower and not leave it up to the resident to request it. On 06/10/26 at 4:50 P.M., an interview with the Director of Nursing (DON) revealed shower documentation was done on the paper bathing sheets. She acknowledged Resident #78 reported she went without a shower for six days, after she returned to the facility from the hospital on [DATE], and the shower documentation provided confirmed that. She talked to the unit manager and he did not feel that was accurate. She was asked to provide any additional shower documentation they had to show showers were provided or offered to the resident between 06/04/26 and 06/09/26. She was only able to find one additional bathing sheet that showed the resident was offered a shower on 06/07/26 and refused. It was consistent with what the aide interview said about the resident yelling out that she wanted a bed bath, but did not match up with her coworker documenting that it had been offered and refused. There was still no documentation for any showers being completed or offered and refused on 06/04/26, 06/05/26, 06/06/26, 06/08/26, or 06/09/26. This deficiency represents non-compliance investigated under Complaint Number 3030059.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure a comprehensive assessment was completed to determine the type of urinary incontinence and failed to implement an effective treatment plan to address the resident's incontinence. This affected one resident (#54) of two residents reviewed for bowel and bladder incontinence. The census was 68. Findings include:Record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including left rib fracture, urinary tract infections, subarachnoid hemorrhage, metabolic encephalopathy, dementia, chronic kidney disease, and obstructive and reflux uropathy. Review of Resident #54's admission minimum data set (MDS) assessment completed on 05/07/26 revealed a brief interview for mental status score was unable to obtain. The resident had no displayed behaviors. The resident utilized a walker for mobility. The resident required set up or clean-up assistance for eating, supervision or touching assistance for upper body dressing, oral hygiene, moderate assistance for lower body dressing, personal hygiene, toileting hygiene, showering and bathing, and for mobility and transfers. The resident was frequently incontinent of bowel and urine.Review of Resident #54's care plan initiated on 05/11/26 revealed the resident had incontinence related to weakness, age related changes, and obstructive/ reflux uropathy.Review of Resident #54's medical record revealed no documented evidence of incontinence care being completed on 05/12/26, 05/13/26, 05/15/26, 06/02/26.Review of Resident #54's medical record revealed Resident #54 had incontinence care provided only once a day on 05/14/26, 05/16/26, 05/18/26, 05/19/26, 05/20/26, 05/23/26, 05/25/26, 05/26/26, 05/28/26, 05/30/26, 06/03/26, 06/04/26, 06/05/26, 06/06/26, 06/07/26, and 06/08/26.Interview on 06/08/26 at 1:48 P.M. with Resident #54's representative revealed they have had some issues with the resident being provided timely, adequate incontinence care. When they come in to visit, they can smell urine and see her (incontinence) brief was soaked, sometimes including her pants.Interview on 06/15/26 at 2:00 P.M. with the Director of Nursing (DON) confirmed there was a lack of evidence regarding incontinence care being completed for Resident #54. The DON stated the resident was not on a urinary toileting trial/ program and they did not know the type of urinary incontinence the resident had.Review of undated facility policy titled Urinary Continence and Incontinence - Assessment and Management revealed the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. Management of incontinence will follow relevant clinical guidelines. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections. As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence. Relevant information related to urinary continence includes history of urinary incontinence, factors precipitating incontinence, and associated symptoms; previous treatment and management attempts and response to interventions; observations including wet bed or clothing; functional and cognitive capabilities or limitations that could affect continence; additional information such as the type and frequency of physical assistance necessary for the resident to access the toilet, commode and the scope of prompting needed to encourage urination; and environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet. Minimum data set criteria for frequent incontinent means the resident has had at least seven (7) episodes of bladder incontinence in the previous seven days. A check and change strategy involves checking the resident continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin.Review of undated facility policy titled Charting and Documentation revealed all services provided to the resident or any changes in the resident's medical or mental condition shall be documented in the resident's medical record. Observations, services performed, procedures, treatments, etc. must be documented in the resident's (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical records. Incidents, accidents, or changes in the residence condition must be recorded. This deficiency represents non-compliance investigated under Master Complaint Number 3045760 and Complaint Number 3030059.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 observation, interview, record review, and policy review the facility failed to ensure a resident's meal intakes were monitored and the resident was comprehensively assessed regarding weight loss. This affected one resident (#54) of four residents reviewed for nutrition. The census was 68. Findings include: Record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including left rib fracture, urinary tract infections, subarachnoid hemorrhage, metabolic encephalopathy, dementia, chronic kidney disease, and obstructive and reflux uropathy. Review of Resident #54's care plan initiated on 05/06/26 revealed the resident had a nutrition risk related to left sided rib fracture, dementia, chronic kidney disease, metabolic encephalopathy, weakness, altered mental status and subarachnoid hemorrhage. Goals included the resident would maintain nutritional status through next review period. Interventions included monitoring the resident's meal intakes. Review of Resident #54's admission minimum data set (MDS) assessment completed on 05/07/26 revealed a brief interview for mental status score was unable to be obtained. The resident had no displayed behaviors. The resident utilized a walker for mobility. The resident required set up or clean up assistance for eating, supervision or touching assistance for upper body dressing, oral hygiene, moderate assistance for lower body dressing, personal hygiene, toileting hygiene, showering and bathing, and for mobility and transfers. The resident is frequently incontinent of bowel and urine. The resident had an ordered therapeutic diet. Review of Resident #54's orders revealed an order dated 05/22/26 for no added salt diet, pureed texture, thin liquids. Review of Resident #54's weights revealed the following:a weight of 127.2 pounds (lbs) on 05/06/26a weight of 115.8 lbs. on 06/03/26; a weight loss of 10.43% in 29 days. There was no evidence nutritional interventions were developed and implemented for Resident #54's weight loss. Review of Resident #54's mini-nutritional assessment completed 05/07/26 revealed a score of 8 indicating the resident was at risk of malnutrition. Review of Resident #54's medical record revealed no evidence of any meal intakes including breakfast, lunch, and dinner on 06/04/26, 05/25/26, 05/18/26, 05/15/26, and 05/11/26. Review of Resident #54's medical record revealed no evidence of meal intake for lunch and dinner on 05/13/26, no evidence of dinner intake on 05/14/26 and 05/19/26, and no evidence of meal intake for breakfast or dinner on 06/02/26. Interview on 06/08/26 at 1:48 P.M. with Resident #54's representative revealed they believe the resident had lost weight but had been at the facility for only a month. Resident #54's representative revealed the resident cannot physically feed themselves and they are unsure if the staff of the facility is consistently helping her [Resident #54] eat during every meal. Observation on 06/10/26 at 8:03 A.M. revealed four staff members passing breakfast trays to residents on Hall 200. At the time of the observation, Certified Nurse Assistant (CNA) #75 stated I absolutely will not feed her. Interview on 06/15/26 at 2:00 P.M. with the Director of Nursing (DON) confirmed there was a lack of evidence for Resident #54's meal intakes and the resident was dependent on staff for dining/eating. Review of undated facility policy titled Weight Assessment and Intervention revealed the multidisciplinary team will stive to prevent, monitor, and intervene for undesirable weight loss of the residents. Interventions for undesirable weight loss shall be based on careful consideration of the residents choices, nutritional and hydration needs of the resident, functional factors that may inhibit appetite or desire to participate in meals, chewing and swallowing abnormalities, need for diet modifications, medications that may interfere with appetite, chewing, swallowing, or digestion, and the use of supplementation. The threshold for significant unplanned and undesired weigh loss includes a weight loss of at least 5% in one month. Review of undated facility policy titled Charting and Documentation revealed all services provided to the resident or any changes in the residents medical or mental condition shall be documented in the resident's medical record. Observations, services performed, procedures, treatments, etcetera must be documented in the resident's clinical records. Incidents, accidents, or changes in the residence condition must be recorded.This deficiency represents non-compliance investigated under Complaint Number 3045760

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and policy review the facility failed to ensure sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and considering the number, acuity, and diagnoses of the facility's resident population. This affected 68 of 68 residents residing in the facility. The facility census was 68. Findings include: Interview on 06/08/26 at 9:39 A.M. with Resident #2 revealed there was not enough staff in the facility. It seemed like there were just less and less people to help.Interview on 06/08/26 at 9:41 A.M. with Resident #7 revealed there was not enough staff in the building. There was no specific time staffing is short, its all shifts and all days of the week. When she [Resident #7] calls for assistance, it takes a long time.Interview on 06/08/26 at 11:01 A.M. with Resident #39's representative revealed call lights are always going off, they aren't answered timely, you have to wait a long time for incontinence care or to receive your showers.Interview on 06/08/26 at 1:32 P.M. with Resident #4 revealed the staff is overworked, they are not able to give the time they would like to give, affecting the quality of care as well. The call light response is slow.Interview on 06/08/26 at 1:53 P.M. with Resident #54's representative revealed the staff is not very attentive to the residents. There have been several occasions they [Resident #54's representative] have had to wander down the halls to track someone down to get Resident #54 assistance. If you need assistance no one is there, they [facility staff] are not very attentive to the residents. Interview on 06/08/26 at 3:02 P.M. with Resident #53 revealed there is not enough staff in the facility to meet the needs of the residents, you have to wait a long time for staff to answer your call light.Observation on 06/10/26 revealed Resident #34 initiated their call light at approximately 8:58 A.M. and their call light was responded to by staff at 9:20 A.M.Interview on 06/10/26 at 11:13 A.M .with Resident #34 revealed they had pressed their call button earlier that morning because they needed to use the bathroom. Resident #34 stated it took awhile for someone to respond to their call light. Resident #34 stated there have been times where she waits for the call light to be answered to use the bathroom but she can't hold it, and it causes her to be incontinent. Resident #34 stated she wears a brief, if she has waited awhile and can feel she is about to be incontinent she will hold her brief as close as possible to her to not make a mess, but it never fully catches all of the urine. This causes the bed, and her clothes needing to be changed, it causes more work for the staff, and they are already so busy, so they get more behind, and more people have to wait. Resident #34 stated she knows the staff are busy, and there are other people who need help, and need showers, she understands but she feels like there needs to be more staff. Resident #34 stated all the staff is very nice but there are not enough of them.Interview on 06/16/26 at 10:30 A.M. with Certified Nurses Assistant (CNA) #151 confirmed the facility utilized agency staff (CNA and nurses) to staff the facility. Review of undated facility policy titled Answering the Call Light revealed the purpose of the procedure is to respond to the residents' requests and needs. Answer the residents' call as soon as possible and be courteous in answering the residents' call.This deficiency represents non-compliance investigated under Complaint Number 3030059.