

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365990                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>07/28/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>New Dawn Rehabilitation and Healthcare Center                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>865 East Iron Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      |                                                 |
| <p>F 0697</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on interview and closed record review the facility failed to correctly transcribe a resident's pain medication orders resulting in missed doses and pain. This affected one (Resident #81) of three residents reviewed for pain. The facility census was 72. Findings include: Review of Resident #81's closed medical record revealed an admission date of 07/10/26 at 1:51 P.M. and a discharge date of 07/15/26. Diagnoses included but were not limited to heart failure, chronic kidney disease stage four, anxiety disorder, and unspecified fracture of the fourth thoracic vertebra. Review of Resident #81's Hospice Medication List and orders provided to the facility, dated 07/09/26, revealed an order for Oxycodone 5 milligrams (mg) by mouth every four hours for pain and Oxycodone 5 mg by mouth every four hours as needed for pain. Review of Resident #81's admission orders from the facility dated 07/10/26 revealed an order for Oxycodone 5 mg by mouth every four hours as needed for pain. The facility did not transcribe the scheduled Oxycodone 5 mg every four hours. Review of Resident #81's Medication Administration Record and narcotic sign off sheets revealed the resident received Oxycodone 5 mg on 07/10/26 at 3:31 P.M. and not again until 07/11/26 at 7:45 A.M. Review of Resident #81's pain assessments revealed the following pain levels: 07/10/26 at 1:47 P.M. a pain level of 9 out of a possible 10 pain rating (on a pain scale of 1-10 with 1 being minimal pain and 10 being the worst pain the resident has felt). On 07/10/26 at 3:31 P.M. a pain level of 10. On 07/10/26 at 6:09 P.M. a pain level of 2. On 07/11/26 at 5:59 P.M. a pain level of 6. There was no documented pain assessment completed from 07/10/26 after 6:09 P.M. until 07/11/26 at 5:59 P.M. Review of Resident #81's nursing progress notes revealed on 07/11/2026 at 7:45 A.M. revealed the resident (was) crying (and) states she is having back pain of 10. Pain medication (was) given at this time. On 07/11/26 at 8:15 A.M. revealed Hospice called to review orders. They said that the hospice nurse would be coming in to the facility to review medications and give corrections if needed. The resident (is) resting quietly in bed at this time. On 07/11/26 at 9:09 A.M. revealed the hospice nurse here to review medications. The resident continues to rest quietly in bed. no signs or symptoms of pain except when gotten up to the bathroom. On 07/11/26 at 11:45 A.M. revealed pain medication was given as ordered. Medication is scheduled every four hours. Review of Resident #81's care plan dated 07/15/26 revealed the resident has pain. Interventions included anticipate the resident's need for pain relief and respond immediately to any complaint of pain; Evaluate the effectiveness of pain interventions every shift and as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition; and Monitor/record pain characteristics every shift and as needed. During an interview on 07/23/26 at 11:23 A.M. LPN #123 reported she was the nurse who admitted Resident #81. She stated hospice had provided her a list of medication orders which she transcribed. LPN #123 reported she believed the Oxycodone 5mg was to be as needed and she did not see that it was ordered on a scheduled basis. She continued that the resident's family had medicated her pain prior to bringing her in and she also administered (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.

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|--------------------------------------------------------------------------|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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| F 0697<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | medication during her shift. LPN #123 stated when she left around 7:00 P.M., the resident was not in pain. During a phone interview on 07/23/26 at 12:10 P.M. Family Member #111 reported she received a phone call from Resident #81 on 07/11/26 around 8:00 A.M. Family Member #111 stated the resident reported she had not received her scheduled medication all night and was experiencing pain. During a phone interview on 07/23/36 at 1:54 P.M. Hospice Registered Nurse (RN) #110 reported at the time of Resident #81's admission to the facility, she was supposed to be ordered Oxycodone 5 mg every four hours and then Oxycodone 5 mg as needed for breakthrough pain every four hours. During an interview on 07/23/26 at 11:43 A.M. Clinical Manager #112 verified, upon review of Resident #81's record, Resident #81's Oxycodone 5 mg was transcribed incorrectly resulting in missed doses during the night. She stated Hospice arrived the next morning and adjusted her medication. This deficiency represents non-compliance investigation under Complaint Number 3092718. |                                                                                      |                                                 |