

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, review of the facility's investigation, facility policy review and interviews, the facility failed to provide necessary and timely treatment for Resident #10 following a reported injury by the resident. This affected one resident (#10) of three residents reviewed for accident hazards. Actual harm occurred on 04/18/26, when Resident #10 reported to staff that someone dropped her last night while getting changed and she had left knee pain. The resident's left knee was noted to be swollen, and she could only slightly lift her knee. Licensed Practical Nurse (LPN) #15 administered as needed Tylenol for pain. LPN #15 failed to notify the resident's medical provider of the reported fall and change in condition of Resident #10 resulting in delaying necessary treatment including x-rays and orthopedic consult. On 04/20/26, two days after the reported incident, the resident continued to have pain and swelling. The medical provider was notified and ordered an x-ray on 04/20/26 that confirmed the resident had a comminuted fracture (caused by trauma) of the distal femur. The resident was transported to the emergency room for a trauma consult on 04/21/26. Orthopedics deemed the resident a non-surgical candidate and recommended palliative approach with pain management and knee immobilizer due to the resident was non-ambulatory. The resident was admitted to hospice services on 04/27/26 and ordered Oxycodone 2.5 milligrams (mg) every two hours for pain. Findings include: Medical record review revealed Resident #10's most current admission to the facility was 06/05/22 with diagnoses including dementia, insomnia, unsteadiness on feet, difficulty walking, abnormal posture, unspecified fall, reduced mobility, muscle weakness, history of transient ischemic attack (TIA), anemia, depression, anxiety, bipolar, and paranoid personality disorder. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing and vision, spoke clearly, and understood others and self. The resident's brief interview for mental status (BIMS) score was 11 (moderate cognition impairment) out of 15. The residents' inattention, disorganized thinking and altered level of consciousness was noted to fluctuate. The residents had no limitation in range of motion, behaviors or rejection of care. The resident was dependent on staff for hygiene, lower body dressing, and transfers. Resident #10 used a manual wheelchair for mobility. The resident had no pain during the assessment period and was not receiving scheduled pain medication. Review of Resident #10's behavior plan of care initiated on 04/09/26 and revised 04/22/26 (a day after fracture was confirmed) revealed the resident displayed behaviors of making false allegations regarding her husband cheating on her, staff not treating her right, and falsehood about care. Resident #10 was resistive to care at times and refused medications, showers, changing clothing and declined to use leg rests on her wheelchair. Review of Resident #10's medication administration and nursing progress notes dated 04/17/26 revealed no evidence the resident had an accident or injury or received as needed pain medication. Review of Resident #10's medication administration progress (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
--	-------	-----------

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 06/17/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	note dated 04/18/26 at 9:30 A.M., revealed LPN #15 administered Acetaminophen 325 mg two tablets by mouth for pain. There was no documented evidence of where the pain was located. Review of Resident #10's nursing progress note authored by LPN #15 dated 04/18/26 at 12:01 P.M., revealed the resident was complaining of left knee pain. The resident stated to aides they dropped me last night while I was getting changed. Midnight nurse or aide did not report any incident. Resident #10's left knee was swollen, with no redness and skin intact. Resident was able to move toes and ankles of the left leg and could slightly lift the knee. Resident was given as needed medication; resident was resting in bed. Review of Resident #10's medication administration note dated 04/18/26 at 12:32 P.M., revealed the Acetaminophen was effective and the resident's follow up pain scale was zero out of 10. Review of Resident #10's shower sheet dated 04/19/26 authored by Certified Nurse's Aide (CNA) #35 and signed off by LPN #71 revealed CNA #35 documented she gave Resident #10 a bed bath because of her knee. The resident said night shift had dropped her while changing her on 04/18/26, so since she was still yelling in agony with the slightest movement, we just gave her a bed bath and changed her sheet. Review of Resident #10's medication administration record (MAR) dated 04/20/26 at 9:30 A.M., revealed the resident received Acetaminophen 325 mg two tablets by mouth for pain rated five out of 10 (1-10 pain scale). There was no indication where the pain was located. There was no evidence that the resident's medical provider was notified of the resident's reported fall, pain, and limitation in range of motion. Further review of Resident #10's nursing notes revealed no further documentation regarding the resident's knee, pain, or incident until 04/20/26 when LPN #4 documented a late entry at 10:29 A.M., that indicated new orders were obtained per the resident's physician for an x-ray of the left knee. Floor nurse was updated. Review of the facility provider communication binder (not part of the resident's medical record) revealed on 04/20/26 an unknown staff at unknown time had written a note that the resident in room [ROOM NUMBER], bed 2 (Resident #10), had complaints of a fall on Friday and had complaints of left leg pain, swelling, and crying when leg was moved. X-ray??? Review of Resident #10's visiting physician note authored by Medical Doctor (MD) #101 dated 04/20/26 revealed the resident was seen today to follow up on a fall which occurred on 04/17/26. The resident was now complaining of left leg pain, and she was crying when it was moved. Staff reported that there was swelling. Per the documentation in the medical record on 04/18/26 the resident had reported to aides that she was dropped last night while she was getting changed. The resident's medication included Acetaminophen 325 mg two tablets every six hours as needed and Acetaminophen PM 500-25 mg at bedtime for insomnia. The provider's assessment and plan included getting an x-ray of the left knee, hopefully today, as it was swollen and resident stated it was painful. Review of Resident #10's order dated 04/20/26 revealed left knee x-ray STAT for increased pain and swelling. Review of Resident #10's left knee radiology report dated 04/20/26 at 6:10 P.M. revealed the resident had a comminuted impacted fracture of the distal femur that was identified. The fracture did involve the articular surface laterally. Anterior lateral displacement of the distal fracture fragments was noted. A large joint effusion was identified. Soft tissue swelling was noted. Moderate degenerative changes were noted. Review of Resident #10's medical record revealed no evidence MD #101 or a nurse practitioner (NP) were notified of the x-ray results on 04/20/26. The next progress entry was a late entry dated 04/21/26 at 10:31 A.M. authored by LPN #4 that revealed the results were obtained and NP updated. The noted indicated to send the resident to the emergency room for further evaluation per daughter and NP. Review of a visiting Nurse Practitioner (NP) note authored NP #102 dated 04/21/26 revealed yesterday the resident had reported knee pain to the MD and an x-ray was obtained. The resident continued to complain of pain. The x-ray results were reviewed today (per x-ray report the results were completed on 04/20/26 at 6:10 P.M.) and there was (continued on next page)		

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 06/17/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a comminuted impacted fracture of the distal femur. Fracture fragments were noted and there was a large joint effusion identified as well as soft tissue swelling. The resident at this point of time will be sent to the emergency department for evaluation of the fracture and need for surgical intervention moving forward. Review of Resident #10's hospital emergency notes authored by MD #103 dated 04/21/26 revealed the resident's daughter was at the bedside and endorses that the resident had an unwitnessed fall at the nursing home and was not able to confirm the mechanism of injury. The resident appears to be alert and oriented times three at bedside, however unable to provide any significant history in regard to the fall or incident leading up to it. The resident had noted pain and tenderness in the distal thigh region. The resident had a computed tomography (CT) scan of the femur that indicated a comminuted distal femoral fracture with displaced fragments and impaction. Diffuse osteopenia (indicates early bone loss that is less severe than osteoporosis). There was a large knee joint effusion with fat/fluid levels. After a long discussion with the resident's daughter given that the resident was non-ambulatory and relatively non-painful she was okay with proceeding with conservative treatment of her distal femur fracture and knee immobilizer. The resident was to maintain non-weight bearing restrictions in the knee immobilizer and to follow up as outpatient with orthopedics. Review of Resident #10's April 2026 MAR revealed the resident had only received the one dose of Acetaminophen. On 04/28/26 Oxycodone 2.5 mg was ordered every two hours for pain. The resident received a dose of the Oxycodone on 04/28/26, 04/29/26, 04/30/26. Review of the facility's fall investigation dated 04/20/26 revealed the fall/incident occurred on 04/18/26. The collaborative team meeting was held to review the incident dated 04/18/26. Nurse was called to the resident's room due to left knee pain. Nurse assessed the resident's knee with swelling noted without redness, skin intact, bilateral knees equal in temperature. Range of motion within normal limits to left ankle and toes. Resident would not bend left knee due to increased pain stating, they dropped me while I was getting changed. Resident unable to explain what happened at time of fall, who was with her, so resident repeated, I was dropped when I was getting changed. Nurse offered as need pain medication and the resident accepted. Further investigation of all staff conducted; staff deny recent falls however, staff reported that during wheelchair transport to shower, resident left leg/heel touched down to floor and was jarred. MD and resident representative aware, new order for x-ray. Resident was currently in bed resting. Leg rests to be on at all times when resident in wheelchair, staff education provided. Care plan reviewed and updated as necessary. The following staff statements were obtained as part of the facility's investigation: Review of staff statements revealed no evidence Agency LPN #104, who worked on 04/17/26 was interviewed. Review of CNA #98's written statement dated 04/21/26 and witnessed by LPN #4 revealed she was transporting Resident #10 to her room in wheelchair before dinner when the resident stated, my foot keeps falling. The CNA told the resident to try and keep her feet up. After stopping the wheelchair immediately and checking over the resident's foot. Review of CNA #70's statement dated 04/21/26 revealed on Friday (04/17/26) the resident reported someone had dropped her and said her left leg hurt and the CNA had told next shift about it. On Saturday (04/18/26) the CNA was told that the resident had someone coming to do an x-ray. When it came to be Sunday (04/19/26), CNA #70 told two of the nurses on night shift to come to Resident #10's room to look at her leg. Resident #10 then said when she was in the wheelchair someone was going fast and her leg got caught. Review of LPN #7's written statement dated 04/21/26 and witnessed by LPN #4 revealed LPN #17 had reported the resident had some pain during the night, and the doctor was updated with new orders for x-ray. Review of LPN #15's written statement dated 04/22/26 revealed she was called to Resident #10's room due to the resident complaining of left knee pain. The LPN evaluated the resident's left knee; resident was able to move toes, hip, and ankle with (continued on next page)		

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 06/17/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	no pain or issues. Resident's knee was swollen, no redness, equal in temperature with right knee and skin was intact. Resident stated to this nurse they dropped me last night when I was getting changed. The nurse asked day shift aides if they had got in report that the resident had fallen. All day shift aides stated they had not heard of her falling. Resident was given as needed Tylenol at 9:30 A.M., and it was effective. This nurse passed on to oncoming nurse to monitor for increased pain or discomfort. Interview on 06/11/26 at 12:45 P.M., with the Director of Nursing and LPN #4 revealed at the time of the incident the DON was off and LPN #4, who was the Unit Manager, completed the investigation. The DON reported she had reviewed the fall/incident report and confirmed the date the incident report was completed was inaccurate due to the facility believed the incident occurred on 04/17/26. The DON reported the injury was of unknown origin and was not reported to the State Agency. The DON and LPN #4 confirmed there was a delay in medical provider notification and treatment for Resident #10 beginning on 04/17/26 when CNA #70, who worked night shift on the Friday (04/17/26), had documented the resident had reported someone had dropped her and her left leg was hurt and the CNA did not report the incident until the next shift on Saturday (04/18/26). The DON confirmed the delay in treatment continued when LPN #15 assessed the resident on 04/18/26, however never reported the incident or injury to the resident's medical provider. The DON confirmed that LPN #15 was given a disciplinary action form as a result of not reporting the incident. LPN #4 confirmed she did not obtain a statement from the Agency Nurse (LPN #104) who worked the night on 04/17/26 and provided care to Resident #10. Per the DON, on 04/19/26 CNA #35 completed the shower sheet that was signed by LPN #71 that indicated the resident was not given a shower because she was yelling in agony with the slightest movement and reported staff had dropped her, however staff still never documented or reported the change in condition or the incident to the resident's medical provider. LPN #4 stated that on Monday 04/20/26 the Administrator had notified her of the incident, and she notified the medical provider. The provider visited the same day and ordered an x-ray. The x-ray results were received on 04/20/26, however the results were not reviewed until 04/21/26 by the NP. The DON verified the x-ray results identified Resident #10 had a comminuted fracture, and the family had requested she be sent to the emergency room. The family elected palliative care (hospice) and declined surgery and orthopedic consult. The DON and LPN #4 reported the only explanation they could determine was that CNA #98 verbally reported she was transporting Resident #10 in the wheelchair without the footrest and jarred her leg and the resident said ouch, however there was no statement or supporting evidence to support the theory. CNA #98 was disciplined for not using footrest. The DON confirmed there was no documentation on 04/17/26 regarding the incident reported to CNA #70, no evidence of documentation on 04/19/26 regarding the resident's pain or assessment of the resident's leg. Interview on 06/11/26 at 1:02 P.M., with CNA #98 confirmed she had worked on 04/17/26 and provided care to Resident #10. The CNA confirmed she had given the resident a shower and left her up in the wheelchair to have dinner in the dining room. While she was pushing the resident back to her room after dinner the resident kept reporting her foot was falling. The CNA confirmed the wheelchair did not have footrest on it and she had the resident hold her legs out straight and she pushed her down the hallway. The CNA reported she doesn't recall the resident feet touching the floor, feeling any resistance, running over the resident's foot, jarring the resident feet/leg, or the resident saying ouch during the transport. The CNA reported that the resident reported to her on Saturday (04/18/26) that night shift had dropped her out of bed. Interview on 06/11/26 at 2:00 P.M., with MD #106 (who was covering for MD #101) and the DON revealed due to the resident's age and osteoporosis it would not take much to cause a traumatic fracture. The MD reported if staff had dropped the resident he would have expected more trauma. The MD confirmed the fracture was of unknown origin. The DON (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and MD #106 confirmed there was no documentation or evidence the provider was notified of the change of Resident #10's condition (leg pain and swelling) and allegation she was dropped until three days later on 04/20/26. Interview on 06/11/26 at 2:27 P.M., with CNA #35 confirmed she had provided care to Resident #10 on 04/19/26 and the resident was screaming out in pain, and her left leg was more swollen than usual. The CNA confirmed she had reported the finding to LPN #71. Attempts to interview Resident #10 throughout the survey were unsuccessful. The resident was not able to answer questions appropriately. Review of the facility's policy titled Charting and Documentation dated 2021 revealed all services provided to the resident, or any change in the resident's medical or mental condition, shall be documented in the resident's medical record. Incidents, accidents, or changes in resident's condition must be recorded.		

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 06/17/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents receiving psychotropic medications were provided education on the risks/ benefits of those psychotropic medications for them or their resident representative to be able to give an informed consent for the use of those medications. This affected five residents (#3, #8, #9, #53, and #76) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included depression and anhedonia (inability to experience pleasure or a diminished interest in activities that were once enjoyable). Review of Resident #3's physician's orders revealed he had an order to receive Zoloft (an antidepressant) 75 milligrams (mg) by mouth (po) once daily for depression. He also had an order to receive Remeron (an antidepressant) 15 mg po once daily for an appetite stimulant. Review of Resident #3's electronic medical record revealed there was no documented evidence of the resident and/ or his representative to have been provided education on the risks/ benefits of his psychotropic medication (Zoloft and Remeron) to be able to provide an informed consent. On 06/09/26 at 3:20 P.M., an interview with the director of nursing (DON) confirmed there was no evidence of the resident having been provided education on the risks/ benefits on the use of the two psychotropic medications the resident was receiving. She provided a copy of a consent form to receive psychiatric services, but denied they had an informed consent obtained from the resident regarding his use of Zoloft and Remeron. She acknowledged the facility should be obtaining informed consents from any resident and/ or their family, who were receiving psychotropic medications. She denied that they had been doing that, since it was added as a requirement, but would start doing so from that point on. 2. Review of Resident #53's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, major depressive disorder, and generalized anxiety disorder. Review of Resident #53's physician's orders revealed she had an order to receive Zoloft 25 mg po once daily for depression. The order originated on 06/20/25. Further review of Resident #53's medical record revealed it was absent for any evidence of the resident having been provided with education on the risks/ benefits of taking Zoloft for her to be able to give an informed consent. On 06/09/26 at 3:20 P.M., an interview with the DON revealed they had a consent to treatment form for the Resident #53 receiving psychiatric services, but she could not find evidence of an informed consent being obtained from the resident or her representative pertaining to the use of her Zoloft. She acknowledged they were required to obtain informed consents for the use of any psychotropic medications for a resident by educating them on the risks and benefits of treatment with that (continued on next page)		

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 06/17/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication before it was initiated. She denied they had been doing so, but would start ensuring that was being provided when psychotropic medications were used for a resident. 3. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including mood disorder, dementia, schizoaffective disorder, post-traumatic stress disorder, visual hallucinations, delusions, mild cognitive impairment, anxiety, major depressive disorder, hemiplegia, hypertension, transient ischemic attack, cerebral infarction, and osteoarthritis. Review of Resident #9's orders revealed an order for Ativan oral tablet 0.5 milligram (mg) (lorazepam). Give 0.5mg by mouth two times a day related to delusional disorders. Review of Resident #9's orders revealed an order for risperidone tablet 0.5 mg. give one tablet by mouth one time a day for schizoaffective disorder and give two tablets by mouth at bedtime for schizoaffective disorder. Review of Resident #9's medical record revealed no documented evidence of the resident and/ or their representative to have been provided education on the risks/ benefits of their psychotropic medication (Ativan and Risperidone) to be able to provide an informed consent. Interview on 06/09/26 at 4:00 P.M. with the DON confirmed the facility had no evidence of the resident and/ or their representative being provided education on the risks/ benefits or informed consent of the psychotropic medications the resident was taking (Ativan and Risperidone). 4. Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, urinary incontinence, xerosis cutis dementia, depressive episode, osteoarthritis, femur fracture, hypertension, anxiety, major depressive disorder, and myocardial infarction. Review of Resident #8's orders revealed an order for Clonazepam Tablet 0.5 MG. give 0.5 mg by mouth two times a day related to general anxiety disorder. Review of Resident #8's medical record revealed no documented evidence of the resident and/ or their representative to have been provided education on the risks/ benefits of their psychotropic medication (Clonazepam) to be able to provide an informed consent. Interview on 06/09/26 at 4:00 P.M. with the DON confirmed the facility had no evidence of the resident and/ or their representative being provided education on the risks/ benefits or informed consent of the psychotropic medications the resident was taking (Clonazepam). 5. Medical record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses of depression, anxiety, and insomnia. Review of Resident #76's orders and medication administration records dated June, 2026 revealed the resident was ordered and received the following psychotropic medications: alprazolam 0.25 milligrams (mg) twice daily for anxiety, Remeron 7.5 mg at bedtime for depression, and Quetiapine 50 mg twice (continued on next page)		

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 06/17/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	daily for depression. Review of Resident #76's medical record revealed no evidence the resident or resident's representative was educated on the risk/benefits of psychotropic medications. Interview on 06/11/26 at 11:55 A.M., with the DON confirmed there was no documented evidence Resident #76 or Resident #76's resident representative were provided education on the risk /benefits of psychotropic medications. The DON reported the facility was going to start today obtaining signed consent to ensure resident and representatives were informed on risk/benefits. Review of the facility's policy on Psychotropic Medication Use (revised February 2025) revealed, prior to the initiating the use of psychotropic medications, increasing a dose, or switching to a different psychotropic medication, the staff and physician would review the following with the resident or their representative: non-pharmacological alternatives, the indications and rationale for the recommendation, the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings), and the resident's and/ or representative's right to accept or decline the treatment.		

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 06/17/2026
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)		
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.		

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 06/17/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Review of review of the facility infection control log, interview, and policy review the facility failed to have a comprehensive infection control program and failed to ensure staff were knowledgeable on the laundry process for infectious linens. This affected all 68 residents residing in the facility. The facility census was 68. Findings include: 1. Review of the infection control log dated 06/2025 to 06/2026 revealed no evidence the log included trending of infections. In addition there was not an infection control log for 06/2026. Further review of the April 2026 infection control log revealed the log was not comprehensive to include infection types and microorganisms. On 04/09/26 the log indicated Resident #4's infection type was labs and microorganism was elevated white blood cells. There were five residents listed as having urinary infections and the microorganism was listed as UTI. The log indicated there were 24 residents on isolation, however, didn't indicate the type of isolation or the organism/type of infection that required isolation. There were 39 infections listed on the log for April 2026. Review of the May 2026 infection control log revealed there were two urinary tract infections, however the microorganism indicated UTI. On 05/14/26 the log indicated Resident #4's infection type was labs and microorganism was elevated white blood cells. The log indicated there were nine residents on isolation, however, didn't indicate the type of isolation or the organism/type of infection that required isolation. There were seven residents treated for a vaginal infection. There was 24 infections listed on the log for May 2026. Interview on 06/15/26 at 11:15 A.M., with Licensed Practical Nurse (LPN)/Infection Preventionist (IP) #4 confirmed there was no evidence the facility had been trending infections from 06/2025 to 06/2026. The LPN/IP #4 confirmed there were new infections in June 2026, however she had not started the log timely. The LPN/IP #4 reported she just took over the infection control program about three months ago and she was still learning. The LPN/IP #4 confirmed she could not review the logs for the last year to identify if there was a trend in infections. The LPN/IP #4 confirmed April and May 2026 logs did not include the type of infection on all the residents nor the correct microorganism for urinary tract infections. LPN/IP #4 confirmed the April 2026 infection log indicated there were 24 residents on isolation and nine in May 2026, however there was no indication/organisms why or type of isolation. The LPN/IP #4 reported some were just enhanced barrier precautions. The LPN/IP #4 confirmed there was a trend of vaginal infections in May 2026, but she had not investigated to determine the cause. Review of the facility's policy titled Surveillance for Infection dated 2001 revealed the purpose of the surveillance of infections was to identify both individual cases and trends of epidemiologically significant organisms and Health care -associated infection to guide appropriate interventions and to prevent future infections. Nursing staff will monitor residents for signs and symptoms that may suggest infections, according to current criteria and definition of infections, and will document and report suspected infections to the charge nurse as soon as possible. Daily record detail information about the resident and infection on an individual infection report form. (continued on next page)		

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 06/17/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Interview on 06/15/26 at 10:15 A.M. with Laundry Attendant #105 revealed the certified nurses' aides (CNA) collect dirty linen. All dirty linen is placed in the dirty/ soiled room. Isolation linen is placed in red bags and then into the dirty/ soiled room. Laundry Attendant #105 stated housekeeping/ laundry will then collect the linen from the dirty/ soiled room and bring it into the laundry room. Isolation linen is kept separate by placing it in red bags. Laundry Attendant #105 stated they do not know what type of isolation or what (infection) the resident is on isolation for, they just keep any isolation in the red biohazard bag. When washing linen, whether in the red biohazard bag for isolation or regular linen they utilize the chart on the wall for settings to wash the linen on [laundry formula chart]. Laundry Attendant #105 stated it depends on how soiled items in the red bags are, if they keep them separate from regular linen while washing. Review of the Laundry formula chart revealed Heavy soiled linen is washed on setting #1. Personal items with no bleach is washed on setting #5. Rags and mops are washed on setting #7. Bibs or a short wash is washed on setting #6. Review of undated facility policy titled Laundry and Bedding, Soiled revealed soiled laundry and bedding shall be handled, transported and processed according to best practices for infection prevention and control. Review of undated facility policy titled Medical Waste Handling revealed medical waste will be handled safely in accordance with regulatory requirements. Contaminated linens and personal items will be laundered separately and stored in biohazard bags and/ or designated area prior to laundering.		

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 06/17/2026
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)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review the facility failed to maintain an effective antibiotic stewardship program. This affected all 68 residents residing in the facility. The facility census was 68. Findings include: 1. Review of infection control program dated 06/2025 to 06/2026 revealed no evidence of an antibiotic stewardship program that included documentation of the indication, dose, and duration of the antibiotic, review of laboratory reports to determine if the antibiotic was indicated or needed to be adjusted. There was no evidence of an infection assessment tool or management algorithm being used when prescribing and a system to monitor antibiotic use. There was no system to monitor antibiotic use. Interview on 06/15/26 at 11:15 A.M., with Licensed Practical Nurse (LPN)/Infection Preventionist (IP) #4 revealed she recently took over the infection control program three months ago and was still learning. The LPN/IP #4 reported there was no documented evidence from 06/2025 to 06/2026 to determine if residents met criteria for treatment or not. LPN/IP #4 confirmed the facility was utilizing the McGeer's criteria however she doesn't complete the McGeer's criteria form or document if the resident met or didn't meet criteria anywhere. The LPN/IP #4 reported she doesn't attend the morning meetings and she doesn't always know when a resident was ordered an antibiotic until it was too late. LPN/IP #4 confirmed the facility did not have a system in-place to effectively monitor antibiotic use. Interview on 06/15/26 at 11:22 A.M., with the Director of Nursing (DON) revealed she took over the DON position in January 2025, and she had not provided education to the nursing staff regarding the McGeer's criteria. 2. Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnosis including diabetes, obstructive and reflux uropathy, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the infection control log dated 04/2026 revealed Resident #12 was treated with Doxycycline (antibiotic) for an upper respiratory infection. The chest x-ray was negative. There was no evidence that the resident met criteria for antibiotic treatment, the dosage or strength of the antibiotic, or justification for antibiotic use. Review of Resident #12's order dated 04/23/26 revealed an order for a chest x-ray for a harsh cough and rhonchi. Review of Resident #12's chest x-ray dated 04/23/26 revealed no acute disease process. Review of Resident #12's medication administration record dated 04/2026 revealed the resident was ordered and received Doxycycline 100 milligrams (mg) one twice daily from 04/25/26 to 05/01/26. Interview on 06/15/26 at 2:14 P.M., with LPN/IP #4 revealed after reviewing the resident's medical record the resident did not meet criteria per McGeer's for antibiotic treatment. 3. Medical record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, hypothyroidism, diabetes mellitus, hypercholesterolemia, hypertension, bilateral osteoarthritis of knee, benign prostatic hyperplasia with lower urinary tract symptoms, and history of venous thrombosis and embolism. Review of Resident #6's bladder incontinence plan of care dated 02/03/26 revealed to monitor/document for signs and symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of Resident #6's quarterly MDS dated [DATE] revealed the resident was always incontinent of bladder and bowel. He was not on a toileting program. Review of Resident #6's progress notes dated 05/2026 to 06/10/26 revealed no evidence Resident #6 had signs or symptoms of a urinary tract infection. Review of urology fax dated 05/26/26 revealed orders for urinalysis for hydronephrosis of right kidney. Review of Resident #6's urine culture dated 05/30/26 revealed the resident had greater than (continued on next page)		

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 06/17/2026
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)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	100,000 cfu of Escherichia coli and Klebsiella pneumonia in the urine. Ceftriaxone was sensitive to both organisms. The urine was collected on 05/26/26, received on 05/27/26, and verified on 05/30/26. Review of Resident #6's nursing progress note dated 06/01/26 revealed the urine results were faxed to urology. Review of Resident #6's nursing note dated 06/03/26 revealed no new orders were given from urology. Review of Resident #6's nursing progress note dated 06/04/26 revealed the facility's Nurse Practitioner reviewed the urine culture and sensitivity from urology and new orders obtained for a urinary tract infection (UTI) Review of Resident #6's orders dated 06/04/26 revealed Ceftriaxone one gram intramuscular (IM) one time a day for seven days for UTI. Review of Resident #6 medication administration record (MAR) dated 06/2025 revealed the resident started Ceftriaxone (antibiotic) one gram IM for a UTI on 06/05/26. Review of Resident #6 antibiotic therapy plan of care related to UTI dated 06/05/26 revealed to administer medications as ordered, monitor for adverse reaction and secondary infections such as thrush, colitis, and vaginitis. Review of the infection control log dated 06/2025 to 06/2026 revealed there was no infection control log for 06/2026. Interview on 06/10/26 at 9:28 A.M., with Licensed Practical Nurse (LPN)/Infection Preventionist (IP) #4 revealed she doesn't have a log or map (trending) for June (2026) infections. The LPN/IP #4 reported she was not sure if the resident had met criteria for treatment. The LPN/IP #4 reported she just took over IP role three months ago and was still learning. The LPN/IP #4 reported that she uses the McGeer criteria; however, she doesn't complete the forms or documents on the infection control log to ensure residents meet criteria. Interview on 06/10/26 at 11:11 A.M. with LPN #87 revealed the urologist didn't want Resident #6's urine treated, however a few days later the facility's NP had written orders to treat the urine, however there was no documented rational why he wanted the urine treated. Interview on 06/10/26 at 11:30 A.M., with Resident #6 revealed he didn't have pain or any new urinary symptoms prior to starting the antibiotic. The resident reported the only urinary symptom he has had, which he has had for three years now, was dribbling when he urinates. Interview on 06/10/26 at 12:19 P.M. with LPN/IP #4 revealed she had reviewed Resident #6's medical record again and there was no documented evidence the resident had any signs or symptoms of urinary tract infection and he did not meet the McGeer's criteria for antibiotic treatment. Review of the facility's policy titled Antibiotic Stewardship Program dated 2001 revealed the IP or designee would review all antibiotics starts within 48 hours to determine if continued therapy was justified, justified with needed interventions, or not justified. All resident antibiotics regimens would be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include the resident name and medical record number, unit and room number, date symptoms appeared, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome and adverse events. Review of the facility's policy titled Surveillance for Infection dated 2001 revealed the purpose of the surveillance of infections was to identify both individual cases and trends of epidemiologically significant organisms and Health care -associated infection to guide appropriate interventions and to prevent future infections. Nursing staff will monitor residents for signs and symptoms that may suggest infections, according to current criteria and definition of infections, and will document and report suspected infections to the charge nurse as soon as possible. Daily record detail information about the resident and infection on an individual infection report form.		

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 06/17/2026
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe environment when facility dryers were not maintained. This had the potential to affect all residents residing in the facility. The census was 68. Findings include: Observation of the facility laundry room on 06/15/26 at 10:18 A.M. revealed two dryers. Upon opening the lint trap of each dryer an excessive amount of lint in each trap was revealed. Each lint trap was entirely covered in a layer of thick white lint. Build up of the lint in each dryer was excessive to the point lint was also built up on the bottom of the floor of the dryer. Interview on 06/15/26 at 10:18 A.M. with Laundry Attendant #105 confirmed there was an excessive amount of lint built up in the lint trap of each dryer. Laundry Attendant #105 stated it appeared that the amount of lint build up was from more than one day.		

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 06/17/2026
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)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on paper and electronic medical record review, review of emergency binder, interview, and policy review the facility failed to ensure resident advance directives were accurate in all records. This affected four residents (#2, #6, #10, #76) of four residents reviewed for advance directives. Findings include: 1. Medical record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hypertension, anemia, type two diabetes, depression, anxiety, end stage renal disease, and dependence of renal dialysis. Review of resident orders, plan of care, and medical record revealed no evidence of the resident's advance directive. Review of the emergency binder revealed no evidence of Resident #76's advance directive. Interview on 06/09/26 at 9:50 A.M., with Licensed Practical Nurse (LPN) #71 and #87 confirmed there was no documented evidence in the resident's medical record or emergency binder regarding the resident's advance directive (code status). The LPN's reported the first place to look was the emergency binder, then paper chart, then the electronic medical record. 2. Medical record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including dementia, fracture of femur, insomnia, depression, anxiety, anemia, hypothyroidism, diabetes. Review of the emergency binder revealed no evidence of Resident #10's advance directives. Review of Resident #10's signed advance directive dated 04/27/26 revealed the resident code status was changed to do not resuscitate comfort care. Review of Resident #10's orders dated 04/28/26 revealed the resident's advance directives was do not resuscitate comfort care. Review of Resident #10's care plan revised on 04/28/26 revealed the resident's code status was do not resuscitate comfort care. Interview on 06/09/26 at 9:50 A.M., with LPN #71 and #87 confirmed the emergency binder did not include Resident #10's advance directive. The LPN's confirmed the nurses should refer to the emergency binder first during a code situation. 3. Medical record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, hypothyroidism, diabetes mellitus, hypercholesterolemia, hypertension, bilateral osteoarthritis of knee, benign prostatic hyperplasia with lower urinary tract symptoms, and history of venous thrombosis and embolism. (continued on next page)		

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 06/17/2026
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)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's advance directives care plan dated 01/30/26 revealed the resident was a full code. Review of Resident #6's current orders dated 06/2026 revealed the resident was a full code. Review of Resident #6's paper medical record revealed the resident was full code. Review of the emergency binder revealed no evidence of Resident #6's code status. Interview on 06/09/26 at 1:18 P.M., with Licensed Practical Nurse (LPN) #87 confirmed staff were to refer to the emergency binder to verify a resident code status. Review of the facility's policy titled Advance Directives (dated 2001) revealed prior to or upon admission of a resident to the facility, the social services director or designee would provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. The Nurse Supervisor and/or designee would be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. 4. Record review revealed Resident #2 admitted to the facility on [DATE] with diagnoses including atrial fibrillation, peripheral vascular disease, chronic kidney disease, anemia, hypertension, gout, and osteoarthritis. Review of Resident #2's electronic medical record orders revealed an order placed on 05/12/26 for full code status. Review of Resident #2's paper medical record revealed a signed advanced directive dated 01/31/25 for do not resuscitate comfort care (DNRCC) Review of Resident #2's care plan dated 02/08/25 revealed the resident was a DNRCC. Goals included resident advance directives would be reviewed/ revised as needed through the review date and the resident advanced directives will be regarded and respected through the review date. Interventions included properly labeling medical records and following advanced directives labelling protocol. Revise and review advanced directives as needed. And send copies of advance directives during transfers to the hospital/ clinicals. Interview on 06/09/26 at 3:45 P.M. with Licensed Practical Nurse (LPN) #87 confirmed the advanced directives in Resident #2 medical record including electronic and paper do not match including signed consents, orders, and care plans. LPN #87 confirmed they were unsure what Resident #2's current code status was but they would investigate it.		

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 06/17/2026
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)		
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 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. (continued on next page)		

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 06/17/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 .		

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 06/17/2026
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)		
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on menu review, observation, interview, and policy review, the facility failed to ensure food was prepared in a form designed to meet individual needs when the prepared pureed food items were not the proper consistency. This affected five residents (#13, #5, #37, #54, #58) of five residents reviewed for ordered pureed diets. The census was 68. Findings include: Review of facility menu revealed on 06/10/26 lunch included chicken and dumplings, green peas, dinner roll, and chocolate chip bar. Observation on 06/10/26 at 11:30 A.M. revealed Dietary Staff #48 placed chicken and a dumpling/ noodle item into the facility robot coupe. Dietary Staff #48 proceeded to blend the food items. Dietary Staff #48 checked the consistency, scraped the sides, and blended the items again while adding 4 ounces of chicken gravy. Dietary Staff #48 then placed the food into a serving bowl. Surveyor #51519 tasted the pureed item at 11:31 A.M. which revealed gritty pieces of chicken and larger pieces of noodle/ dumpling item. Dietary Staff #48 did not orally check the consistency of the pureed meal. Dietary Staff #48 proceeded to place a lid on the serving bowl and placed it in the warmer to prepare for tray line. Interview on 06/10/26 at 11:33 A.M. with Dietary Manager #62 revealed pureed items should be smooth, with no chunks, no skin, nothing left over. Observation and interview on 06/10/26 at 11:47 A.M. with Dietary Manager #62 confirmed the pureed chicken and dumplings could have been pureed a little longer to ensure proper consistency. Dietary Manager #62 proceeded to take the chicken and dumplings back to the robot coupe to change the consistency. Review of the undated facility policy titled Therapeutic Diets revealed mechanically altered diets as well as all diets modified for medical or nutritional needs will be considered therapeutic diets. The food services manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered.		

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 06/17/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, policy review, and interview the facility failed to report an injury of unknown origin to the state survey agency. This affected one resident (#10) of three residents reviewed for accidents. Findings include: Medical record review revealed Resident #10 most current admission to the facility was 06/05/2022 with diagnosis including dementia, insomnia, unsteadiness on feet, difficulty walking, abnormal posture, unspecified fall, reduced mobility, muscle weakness, history of transient ischemic attack (TIA), anemia, depression, anxiety, bipolar, and paranoid personality disorder. Review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had adequate hearing and vision, spoke clear, and understood others and self. The resident's brief interview for mental status (BIMS) score was 11 (moderate cognition impairment) out of 15. Review of Resident #10's nursing progress note authored by LPN #15 at 12:01 P.M., revealed the resident was complaining of left knee pain. The resident stated to aides they dropped me last night while I was getting changed. Midnight nurse or aide did not report any incident. Left knee was swollen, with no redness and skin intact. Resident was able to move toes and ankles of left leg and can slightly lift knee. Resident was given as needed medication; resident was resting in bed. Review of Resident #10's shower sheet dated 04/19/26 authored by Certified Nurse's Aide (CNA) #35 and signed off by LPN #71 revealed CNA #35 documented she gave Resident #10 a bed bath because of her knee. The resident said night shift had dropped her while changing her on 04/18/26, so since she was still yelling in agony with the slightest movement, we just gave her a bed bath and changed the sheet. Further review of Resident #10's nursing notes revealed no further documentation regarding the resident's knee, pain, or incident until 04/20/26 when there was a late entry by LPN #4 at 10:29 A.M., that indicated new orders were obtained per MD for x-ray of left knee. Review of the facility provider communication binder (not part of the medical record) revealed on 04/20/26 an entry from an unknown author and time that room [ROOM NUMBER] bed 2 (Resident #10) had complaints of a fall on Friday and had complaints of left leg pain, swelled, and crying when leg was moved. X-ray??? Review of Resident #10's visiting physician note authored by Medical Doctor (MD) #101 dated 04/20/26 revealed the resident was seen today to follow up on a fall which occurred on 04/17/26. The resident was now complaining of left leg pain, and she was crying when it was moved. Staff reported that there was swelling. Per the documentation in the medical record on 04/18/26 the resident had reported to aides that she was dropped last night while she was getting changed. Review of Resident #10's order dated 04/20/26 revealed left knee x-ray STAT (immediately) for increased pain and swelling. Review of Resident #10's left knee radiology report dated 04/20/26 at 6:10 P.M. revealed the resident had a comminuted impacted fracture of the distal femur. The fracture did involve the articular surface laterally. Anterior lateral displacement of the distal fracture fragments was noted. A large joint effusion was identified. Soft tissue swelling was noted. Moderate degenerative changes were noted. Review of Resident #10's hospital emergency notes authored by MD #103 dated 04/21/26 revealed the resident's daughter was at the bedside and endorsed that the resident had an unwitnessed fall at the nursing home and was not able to confirm the mechanism of injury. The resident appeared to be alert and oriented times three at bedside, however unable to provide any significant history in regard to the fall or incident leading up to it. The resident had noted pain and tenderness in the distal thigh region. The resident had a computed tomography (CT) scan of the femur that indicated a comminuted distal femoral fracture with displaced fragments and (continued on next page)		

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 06/17/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaction. Diffuse osteopenia (indicates early bone loss that is less severe than osteoporosis). There was a large knee joint effusion with fat/fluid levels. Review of the facility's fall investigation dated 04/20/26 revealed the fall/incident occurred on 04/18/26. The collaborative team meeting was held to review the incident dated 04/18/26. Nurse called to the resident's room due to left knee pain. Nurse assessed knee; swelling noted without redness, skin intact, bilateral knees equal in temperature. Range of motion within normal limits to left ankle and toes. Resident would not bend left knee due to increased pain stating, they dropped me while I was getting changed. Resident unable to explain what happened at time of fall, who was with her, so resident repeated, I was dropped when I was getting changed. Nurse offered as need pain medication and resident accepted. Further investigation of all staff conducted; staff deny recent falls however, staff reported that during wheelchair transport to shower, resident left leg/heel touched down to floor and was jarred. MD and resident representative aware, new order for x-ray. Resident was currently in bed resting. Leg rests to be on at all times when resident in wheelchair, staff education provided. Care plan reviewed and updated as necessary. Review of CNA #98's written statement dated 04/21/26 and witnessed by LPN #4 revealed she was transporting Resident #10 to her room in wheelchair before dinner when the resident stated, my foot keeps falling. The CNA told the resident to try and keep her feet up. After stopping the wheelchair immediately and checking over the resident's foot. Interview on 06/11/26 at 12:45 P.M., with the Director of Nursing and LPN #4 revealed the injury was of unknown origin due to the facility could not confirm what actually caused the fracture, however the only explanation they could determine was that CNA #98 verbally reported she was transporting Resident #10 in the wheelchair without the footrest and jarred her leg and said ouch, however there was no statement or supporting evidence to support the theory. Interview on 06/15/26 at 10:35 A.M., with the Administrator confirmed she did not report the injury to the State Survey Agency. Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property undated revealed an injury of unknown source was an injury is classified as an Injury of Unknown Source when both of the following conditions were met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and the injury was suspicious because the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incident of injuries over time. All unexplained injuries would be investigated by the DON or designee, to ensure that the health and safety of the residents had not been jeopardized. Should a resident be observed with unexplained injuries, the nursing supervisor on duty must complete an investigation. Written statements would be obtained by the supervising nurse on duty. Statements would be from all personnel including consultants, contract employees, volunteers, visitors, family, etc., who may have had contact with the residents during the past 48 hours. The facility staff should immediately report all such allegations to the Administrator and to the State Agency in accordance with the procedures in this policy.		

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 06/17/2026
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident's quarterly Minimum Data Set (MDS) assessment was completed accurately to reflect all known active medical diagnoses. This affected one resident (#3) of 20 residents reviewed for assessments. Findings include: Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included congestive heart failure, adult-onset diabetes mellitus, hypertension, muscle weakness, and difficulty walking. Review of Resident #3's physician's orders revealed he had orders in place to receive Remeron (an antidepressant medication used in the treatment of depression and also as an appetite stimulant) 15 milligrams (mg) by mouth (po) once daily for an appetite stimulant. That order had been in place since 01/11/26. He also had an order for Zoloft (an antidepressant) 75 mg po once daily for depression and anhedonia (the inability to experience pleasure or a profound loss of interest in activities that were once enjoyed). He had been on Zoloft since 02/09/26, with an increase in dose at the current order being given on 05/05/26. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's active diagnoses were coded under Section I. (Active Diagnoses). Section (I.) included a place to code psychiatric/ mood disorders the resident was known to have with depression being one of the diagnoses listed. The MDS assessment was not marked to reflect the resident had an active diagnosis of depression, despite the resident receiving antidepressants for such at the time the MDS assessment was completed. Section (N.) of the MDS assessment included a place to check high-risk drug classes received by the resident during the seven day assessment period (04/01/26- 04/07/26). He was marked as having received an antidepressant during that assessment reference period. Review of Resident #3's medication administration record (MAR) for April 2026 confirmed the resident was receiving antidepressants (Remeron and Zoloft) between 04/01/26 and 04/07/26. The medical conditions listed on the MAR did not include depression and one of his medical conditions despite the MAR showing Zoloft was being used for depression. On 06/09/26 at 4:15 P.M., an interview with the director of nursing (DON) confirmed Resident #3's quarterly MDS assessment dated [DATE] was not coded accurately, as it did not include depression as one of the resident's active diagnoses. She acknowledged the MAR for April 2026 showed the resident was receiving Zoloft and Remeron during that time and depression should have been coded as one of his active diagnoses.		

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 06/17/2026
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)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure Preadmission Screening and Resident Reviews (PASARR) were complete and failed to ensure PASARR recommendations were implemented. This affected two residents (#9, #10) of two residents reviewed for accuracy of PASARR. The census was 68. Findings include: 1. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including mood disorder, dementia, schizoaffective disorder, post-traumatic stress disorder, visual hallucinations, delusions, mild cognitive impairment, anxiety, major depressive disorder, hemiplegia, hypertension, transient ischemic attack, cerebral infarction, and osteoarthritis. Review of Resident #9's orders revealed an order for Ativan oral tablet 0.5 milligram (mg) (lorazepam). Give 0.5mg by mouth two times a day related to delusional disorders. Review of Resident #9's care plan dated 09/07/23 revealed the resident used psychotropic medications related to dementia, anxiety, delusional disorder, and schizoaffective disorder. Review of Resident #9's PASARR dated 02/29/24 had no documentation of the residents diagnosis of delusional disorder. Review of Resident #9's psych service visit dated 03/18/26 revealed the resident had diagnoses of schizoaffective disorder and delusions, hallucinations, dementia with behaviors, depression, anxiety and no medication changes indicated at that time. Interview on 06/11/26 at 9:51 A.M. with Social Service Designee (SSD) #73 confirmed Resident #9's most recent PASARR dated 02/29/24 did not reflect the resident's diagnosis of delusional disorder. 2. Medical record review of Resident #10's PASARR dated 03/30/21 revealed no evidence of delusions, anxiety or paranoid personality disorder. Medical record review revealed Resident #10 was admitted on [DATE] with diagnoses of schizoaffective disorder bipolar type, delusional disorders, dipolar, major depression, anxiety and paranoid personality disorder. Review of Resident #10's annual MDS dated [DATE] revealed the resident was not considered by the State Level II PASARR process to have a serious mental illness and/or intellectual disability or related concern. Further review revealed the resident triggered for Level II evaluation due to schizoaffective disorder, bipolar, dementia with behavioral disturbance and delusional disorder. It was recommended that the nursing facility have a psychiatrist or other mental health provider provide ongoing review of the resident's mental health medication, to be sure they were working correctly. The facility's doctor (continued on next page)		

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 06/17/2026
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)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitors the medication to be sure it is meeting the resident's health care needs. Neurological exams to assess the progression of the resident's neurocognitive disorder. Mental health counseling for the symptoms and behaviors the resident was having. It was recommended that the nursing facility construct a safety plan to help prevent the resident from harming others. The nursing facility should develop a behavioral based treatment plan to offer strategies and tips for staff to deescalate, resident negative behaviors and symptoms. Therapy, encourage activities, and take medication as ordered. Review of Resident #10's current plan of care revealed no evidence of a plan of care for PASARR or a safety plan. Interview on 06/11/26 at 7:51 A.M. with SSD #73 confirmed the PASARR did not reflect the residents' delusions, anxiety and paranoid personality disorder. SSD #73 reported the PASARR was completed prior to admission and was not updated. Interview on 06/11/26 at 8:53 A.M. with MDS Nurse confirmed the annual MDS was inaccurate and didn't reflect serious mental disorder, the resident did not have a safety plan of care, or a PASARR plan of care.		

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 06/17/2026
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a comprehensive care plan was developed to address constipation for a resident receiving a stool softener on a scheduled basis. This affected one resident (#3) of 20 residents reviewed for care plans. Findings include: Review of Resident #3's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included congestive heart failure, adult-onset diabetes mellitus, muscle weakness, and difficulty walking. Review of Resident #3's physician's orders revealed the resident had an order to receive Colace (a stool softener) 100 milligrams (mg) two capsules by mouth (po) twice a day for constipation. The order had been in place since 01/11/26. Review of Resident #3's active care plans revealed the resident did not have a care plan in place to address constipation. On 06/09/26 at 4:15 P.M., an interview with the director of nursing (DON) confirmed Resident #3's comprehensive care plans did not include a care plan to address constipation. She acknowledged the resident was receiving Colace twice a day on a scheduled basis for constipation and should have had a care plan to address that. She stated that was one of the care plans that she had trouble remembering to initiate, when developing the comprehensive care plans.		

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 06/17/2026
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident's quarterly care planning conference was scheduled and the resident and/ or their family was afforded the opportunity to participate in their care planning process. This affected one resident (#7) of one resident reviewed for care planning conferences. Findings include: Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included chronic respiratory failure, dependence on a respiratory ventilator, hypertension, lymphedema, peripheral vascular disease, depression, anxiety disorder, muscle weakness, and abnormalities of gait and mobility. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was known to have a functional limitation in her range of motion of one side of her lower extremities. She used a wheelchair for a mobility device. Further review of Resident #7's medical record revealed an initial care conference was held for the resident on 02/18/26. Her medical record was absent for any evidence of the resident having a quarterly care planning conference held on her behalf since her admission. On 06/08/26 at 9:43 A.M., an interview with Resident #7 revealed she had not been invited to attend any quarterly care planning conferences since being admitted to the facility on [DATE]. She did not recall having any meetings held that included herself, her husband, and different disciplines within the facility for the purpose of reviewing her care, orders, or goals while in the facility. On 06/10/26 at 9:38 A.M., an interview with Licensed Social Worker (LSW) #73 revealed care conferences were to be held every three months (quarterly) for residents. She confirmed they did not have evidence of a quarterly care conference having been completed for Resident #7, since her admission. She calculated how long the resident had been there and confirmed a care conference should have been held in May 2026. She reported the facility's activity director was responsible for scheduling the care conferences when they were due. The activity director had a calendar that she went by and also ran an admission report to see when a resident was due for their first quarterly. On 06/10/26 at 9:51 A.M., an interview with Activity Director #83 revealed it was her responsibility to schedule care planning conferences for the residents, when they were due. She would then send out letters to the families and email all the management team to let them know when a care conference meeting was scheduled. She completed the care conference forms when they were held and had the residents sign to show they attended and received a copy. With the new admissions, she would have to talk with the LSW, after the initial care conference was held, to see if the resident would be there for three months or longer, so a quarterly care conference could be scheduled. She stated she did not feel she was the best person to track when care planning conferences were needing to be scheduled, as she did not know which residents were remaining in the facility long enough to require one. She felt she was kind of the middle person in all that and likely not the best person to schedule them. She relied on information from the social worker on who was going to be there longer than a few months that would require a care planning conference. Review of the facility's policy on Resident/ Family Participation- Assessments/ Care Plans revised April 2016 revealed each resident and his/ her family members were encouraged to participate in the development of the resident's comprehensive assessment and care plan. The resident and his/ her family, and/ or legal representative were invited to attend and participate in the resident's assessment and care planning conference. Care conferences were to be held upon admission, quarterly, and as needed/ upon request.		

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 06/17/2026
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)		
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, (continued on next page)		

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 06/17/2026
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #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.		

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 06/17/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review the facility failed to timely and comprehensively assess a pressure ulcer. This affected one resident (#76) of two residents reviewed for pressure ulcers. Findings include: Medical record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses of chronic pulmonary disease, adult failure to thrive, anemia, type two diabetes, heart disease, fibromyalgia, rheumatoid arthritis, history of transient ischemic attack, end stage renal disease, dependence on renal dialysis, and wedge compression fracture of the first lumbar vertebra. Review of Resident #76's baseline plan of care dated 06/08/26 revealed the resident was at risk for skin breakdown and to monitor and document location, size, and treatment of skin injury. Review of Resident #76's orders dated 06/08/26 revealed to cleanse mid- spine with normal saline, apply skin prep then cover with a border foam dressing three times a week and as needed. Review of Resident #76's medical record revealed no evidence of a comprehensive skin assessment was completed on admission or on the area on the mid spine that required treatment. Review of Resident #76's wound progress note dated 06/08/26 revealed the resident was not evaluated by the wound team today. Resident was very anxious and had behavior during visit. Will re-attempt next visit for skin sweep. Interview and observation of Resident #76 on 06/09/26 at 2:08 P.M., with Licensed Practical Nurse (LPN) #71 confirmed there was no skin assessments in the medical record nor an assessment on the mid- spine. The LPN reported she was not sure if the area on the spine was pressure or non-pressure due to she had not observed the area. The LPN spoke to the unit managers and returned and reported the unit managers told her it was a scratch. At this time, observation of the area revealed the resident had two by two-inch undated dressing on the mid spine. The resident had a red area above and below the dressing approximately four inches above and below the dressing. The LPN removed the dressing and there was a scant amount of serosanguinous drainage noted on the old dressing and an open area on the mid spine the size of pea. The resident reported she has had a bedsore for some time and was told it was caused from lying in bed. The LPN confirmed these findings during the observation. Interview on 06/10/26 at 8:27 A.M. with the Director of Nursing (DON) confirmed there was no skin assessment completed on Resident #76 on admission or on 06/08/26 when a skin alteration was noted and new treatment implemented. Review of Resident #76's skin assessment dated [DATE] revealed the resident had an open area on the mid- spine measuring 0.4 centimeters (cm) by 0.3 cm by 0.0 cm with scant bloody drainage. The type of skin alteration was pending. Interview on 06/11/26 at 11:11 A.M., with LPN #4, who was also the wound nurse, confirmed there was no skin assessment completed on admission or after a skin alteration was noted on 06/08/26. The LPN confirmed the facility still hadn't completed a comprehensive assessment of the mid-spine due to the Wound Nurse Practitioner (NP) only comes on Monday and Thursday and as a LPN she can't stage a wound. The LPN confirmed the Wound NP did not see the resident on 06/08/26 due to the resident was at dialysis and then was sent to the hospital and didn't return until later in the day. Review of the Pressure Ulcer policy (dated 2013) revealed the facility should have a system in place to assure assessments are timely and appropriate changes in condition are recognized, evaluated, and reported to the practitioner, physician, and family and addressed.		

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 06/17/2026
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)		
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 (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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 06/17/2026
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)		
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 05/06/26 a 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 strive 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 weight loss includes a weight loss of at least 5% in one month. Review of undated facility (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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		

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 06/17/2026
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)		
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview the facility failed to ensure a resident's dialysis port was assessed and monitored. This affected one resident (#76) of one resident reviewed for dialysis. Findings include: Medical record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses of anemia, type two diabetes, end stage renal failure, and dependence on renal dialysis. Review of Resident #76's hospital records dated 06/02/26 revealed the resident had an Arteriovenous (AV) fistula (dialysis port). Review of Resident #76's nursing note dated 06/05/26 at 5:46 P.M., revealed the emergency nurse called report and reported the resident had a fistula in the left arm and had 500 milliliters (ml) removed from dialysis today. Review of Resident #76's baseline plan of care dated 06/2026 revealed no evidence of a dialysis plan of care. Review of Resident #76's admission assessment dated [DATE] and 06/06/26 revealed no evidence the resident had an AV fistula. Review of Resident #76's orders dated 06/2026 revealed the resident was ordered dialysis Monday, Wednesday, and Friday. Further review of Resident #76's orders revealed no evidence of orders for staff to assess or monitor Resident #76's AV fistula. Review of Resident #76's medical record revealed no evidence staff were assessing or monitoring Resident #76's AV fistula. Interview on 06/09/26 at 1:38 P.M., with Licensed Practical Nurse (LPN) #71 confirmed there were no orders or evidence Resident #76 AV fistula was being assessed or monitored. The LPN reported she had not assessed the AV fistula yet, but she thought it was in the resident's right arm. Observation on 06/09/26 at 1:38 P.M., of Resident #76 with LPN #71 revealed the resident had a dressing on her right arm. The resident reported she had been receiving dialysis for over a year and had an AV fistula in her right arm. The resident confirmed she had gone to dialysis yesterday and the dialysis nurse had placed the dressing on her fistula. The resident reported usually dialysis has her remove the dressing the next day, however she was too weak to remove it herself. The resident reported she doesn't know how to check the AV fistula to ensure it was functioning. The LPN confirmed there were no orders to remove the dressing, and she would call the dialysis center to obtain orders for the dressing and monitoring of the AV fistula. Interview on 06/10/26 at 8:27 A.M., with the Director of Nursing (DON) confirmed Resident #76 did not have a baseline plan of care for dialysis, no orders to assess and monitor AV fistula, and no orders to remove the dressing.		

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 06/17/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, and policy review, the facility failed to properly store and administer medications. This affected two residents (#42, #22) of eight residents observed in the initial pool. The census was 68. Findings include: 1. Record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including type two diabetes, cellulitis of left lower limb, polyneuropathy, glaucoma, insomnia, peripheral vascular disease, and hypertension. Review of Resident #42's medical record revealed no indication or order for the resident to have medications at bedside or for the resident to self-administer her medications. Observation on 06/08/26 at 2:58 P.M. of Resident #42 revealed a pill cup containing several different medications on the resident's bedside table. Interview on 06/08/26 at 2:58 P.M. with Resident #42 confirmed her medications were in the cup on the bedside table. Resident #42 stated she does not like to take her medications so close to when she eats, it upsets her stomach, so she waits. 2. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including cancer, anemia, atrial fibrillation, gastroesophageal reflux disease, and diabetes mellitus. Review of Resident #22's medical record revealed no indication or order for the resident to have medications at bedside or for the resident to self-administer her medications. Observation on 06/09/26 at 3:56 P.M. of Resident #22 revealed the resident sitting in her room in a recliner chair with her bedside table to the right side. On the bedside table a pill cup with three white capsules were inside. Interview on 06/09/26 at 3:57 P.M. with Resident #22 confirmed her chemo medication was on the bedside table in a medication cup that the nurse had handed her. Interview on 06/11/26 at 7:59 A.M. with Registered Nurse (RN) #52 confirmed medications cannot be left at a resident's bedside. Staff must observe the resident taking the medication and then sign off on the medication administration record after administration. If a resident refuses a medication or wants to wait to take the medication it cannot remain at the bedside. Interview on 06/11/26 at 8:46 A.M. with Certified Nurse Assistant (CNA) #39 revealed they have seen medications in the pill cups at the resident's bedside. CNA #39 stated they do not like it when the nurses, usually agency, leave medications at the resident's bedside because the resident may forget to take it, or not take it but say they did, you are not able to ensure the resident is receiving their medication at the proper time. Review of undated facility policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with prescribed orders. Medications must be administered within the window of their prescribed time. The individual administering the medication must document in the resident's electronic medication administration record after administering.		

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 06/17/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review the facility failed to ensure residents didn't receive unnecessary antibiotic treatment. This affected two residents (#6 and #36) of three residents reviewed for urinary tract infections (UTI). Findings include: 1. Medical record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including urinary tract infection, hypothyroidism, diabetes mellitus, hypercholesterolemia, hypertension, bilateral osteoarthritis of knee, benign prostatic hyperplasia with lower urinary tract symptoms, and history of venous thrombosis and embolism. Review of Resident #6's bladder incontinence plan of care dated 02/03/26 revealed to monitor/document for signs and symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of Resident #6's quarterly minimum data set (MDS) assessment dated [DATE] revealed the resident was always incontinent of bladder and bowel. He was not on a toileting program. Review of Resident #6's progress notes dated May, 2026 to 06/10/26 revealed no evidence Resident #6 had signs or symptoms of a urinary tract infection. Review of urology fax dated 05/26/26 revealed orders for urinalysis for hydronephrosis of right kidney. Review of Resident #6's urine culture dated 05/30/26 revealed the resident had greater than 100,000 colony forming unit (cfu) of Escherichia coli and Klebsiella pneumonia in the urine. Ceftriaxone was sensitive to both organisms. The urine was collected on 05/26/26, received on 05/27/26, and verified on 05/30/26. Review of Resident #6's nursing progress note dated 06/01/26 revealed the urine results were faxed to urology. Review of Resident #6's nursing note dated 06/03/26 revealed no new orders were given from urology. Review of Resident #6's nursing progress note dated 06/04/26 revealed the facility's Nurse Practitioner (NP) reviewed the urine culture and sensitivity from urology and new orders obtained for a urinary tract infection (UTI). Review of Resident #6's orders dated 06/04/26 revealed Ceftriaxone one gram intramuscular (IM) one time a day for seven days for UTI. (continued on next page)		

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 06/17/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's medication administration record (MAR) dated June 2026 revealed the resident started Ceftriaxone (antibiotic) one gram IM for a UTI on 06/05/26. Review of Resident #6's antibiotic therapy plan of care related to UTI dated 06/05/26 revealed to administer medications as ordered, monitor for adverse reaction and secondary infections such as thrush, colitis, and vaginitis. Review of the infection control log dated 06/2025 to 06/2026 revealed there was no infection control log for 06/2026. Interview on 06/10/26 at 9:28 A.M., with Licensed Practical Nurse (LPN)/Infection Preventionist (IP) revealed she doesn't have a log or map (trending) for June (2026) infections. The IP reported she was not sure if the resident had met criteria for treatment. The IP reported she just took over IP three months ago and was still learning. The IP reported that she uses the McGeer criteria; however, she doesn't complete the forms or documents on the infection control log to ensure residents meet criteria. Interview on 06/10/26 at 11:11 A.M. with LPN #87 revealed the urologist didn't want the urine treated, however a few days later the facility's NP had written orders to treat the urine, however there was no documented rational why he wanted the urine treated. Interview on 06/10/26 at 11:30 A.M., with Resident #6 revealed he didn't have pain or any new urinary symptoms prior to starting the antibiotic. The resident reported the only urinary symptom he has had, which he has had for three years now, was dribbling when he urinates. Interview on 06/10/26 at 12:19 P.M. with LPN #4 revealed she had reviewed Resident #6's medical record again and there was no documented evidence the resident had any signs or symptoms of urinary tract infection and he did not meet the McGeer's criteria for antibiotic treatment. Review of the facility's policy titled Antibiotic Stewardship Program dated 2001 revealed the IP or designee would review all antibiotics starts within 48 hours to determine if continued therapy was justified, justified with needed interventions, or not justified. All resident antibiotics regimens would be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include the resident name and medical record number, unit and room number, date symptoms appeared, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome and adverse events. Review of the facility's policy titled Surveillance for Infection dated 2001 revealed the purpose of the surveillance of infections was to identify both individual cases and trends of epidemiologically significant organisms and Health care -associated infection to guide appropriate interventions and to prevent future infections. Nursing staff will monitor residents for signs and symptoms that may suggest infections, according to current criteria and definition of infections, and will document and report suspected infections to the charge nurse as soon as possible. Daily the record detail information about the resident and infection on an individual infection report form. (continued on next page)		

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 06/17/2026
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including vascular dementia, rhabdomyolysis, congestive heart failure, anxiety, reflux uropathy, urine retention, hypertension, presence of cardiac pacemaker, atrial fibrillation, heart failure, and diabetes mellitus. Review of Resident #36's Quarterly MDS dated [DATE] revealed a brief interview for mental status score of five (5) indicating significant cognitive impairment. The resident utilized a wheelchair for mobility, was dependent of staff for putting on/taking off footwear, lower body dressing, toileting hygiene, required moderate for upper body dressing, assistance for oral hygiene, max assist for showering/ bathing, and max assist for personal hygiene, and maximal assistance for mobility. The resident was always incontinent of bowel. Diagnoses included coronary artery disease, heart failure, hypertension, obstructive uropathy, diabetes, non-Alzheimer's dementia, malnutrition, anxiety disorder. The resident received scheduled pain medication. The resident had a life expectancy of less than 6 months. Review of Resident #36's progress note dated 03/21/26 at 7:30 P.M. authored by Registered Nurse (RN) #223 revealed the first dose of cephalexin was given tonight [03/21/26] pulled from machine not yet listed on medication administration record. The nurse wished for the resident to start antibiotic regimen as soon as possible (ASAP). Review of Resident #36's orders revealed an order for Cephalexin Oral Capsule 500 milligram (mg). Give 1 capsule by mouth one time a day for urinary tract infection for seven days starting on 3/22/26 at 8:00 A.M. and discontinue after 7 days on 03/29/26. Interview on 06/15/26 at 1:50 P.M. with the Director of Nursing (DON) confirmed Resident #36 was given an additional dose of their antibiotic (cephalexin) without a physician provider order, or physician notification. Review of undated facility policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with prescribed orders. Medications must be administered within the window of their prescribed time. The individual administering the medication must document in the resident's electronic medication administration record after administering.		

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 06/17/2026
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)		
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy reviews the facility failed to ensure COVID immunization consent forms were dated and failed to have documented evidence of education provided to residents and/ or representative of the risks and benefits of the COVID immunization. This affected one resident (#53) of five residents reviewed for immunizations. The census was 68. Findings include: Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, dementia, osteoarthritis, chronic kidney disease, atrial fibrillation, and hypertension. Review of Resident #53's medical record revealed no evidence of documentation of the resident and/ or representative consenting to or declining the COVID immunization for Resident #53. Interview on 06/15/26 at 9:17 A.M. with Licensed Practical Nurse (LPN) #87 confirmed the COVID immunization consent form for Resident #53 did not have a resident or representative signature and did not have a date. Interview on 06/15/26 at 2:05 P.M. with facility director of nursing (DON) stated the COVID immunization form should have a signature and date. The DON confirmed there was no evidence of the resident and /or representatives being educated on the risks or benefits of the COVID immunization. Review of undated facility policy titled COVID-19 Prevention and Management revealed before offering COVID-19 vaccination, each resident and or resident representative will be provided with education regarding the benefits, risks, and potential side effects associated with the COVID-19 vaccine that they are being offered in a manner that they can understand. Each resident will be offered the COVID-19 vaccine unless immunization is medically contraindicated, or the resident has already been immunized. The facility will maintain documentation that it provided the required COVID-19 vaccine education. The facility will maintain a record of the vaccination status of each resident. Residents and their representatives may accept or refuse a COVID-19 vaccine and change their decision at any time.		