

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policy, the facility failed to maintain the kitchen and nursing unit refrigerator and microwave on unit D in a clean and sanitary manner. This had the potential to affect all residents receiving food from the facility. The facility census was 108. Findings include: 1. Observations during the initial tour of the kitchen on 07/28/25 from 9:04 A.M. through 9:22 A.M. revealed: The reach-in cooler at the end of the steamtable on the bottom inside of the door had dried, various splatters and food debris. The table next to the reach-in where the juice machine and toaster were located, the top shelf had various dried stains around the juice machine and on the wall behind it. The bottom shelf had dried red and brown stains where the boxes of juice and a black piece of machinery sat. The wall where the clean knives were hanging was dirty with various dried stains. The table across from the steam table where the steamer sat, observed on the second shelf where two wire baskets with several serving utensils and scoops with various dried splatters and stains. The bottom shelf that had oil and other food items stored had grease stains. The bottom shelf of the table with the pots and pans had various food debris. There was a large box of thickener that was wide open and had a strand of hair inside of the thickener. The shelf on the wall where the spice containers sat had various food debris/crumbs. Interview on 07/28/25 between 9:04 A.M. through 9:22 A.M., Dietary Manager (DM) #700 verified the above findings. 2. Observation on 07/30/25 at 11:57 A.M. of the lowerator (where the metal pellets are heated to keep the plates warm) was dirty with various smears/debris---the metal pellets sits in the thermal bottom, and the plate of food sits on top of the metal pellet then covered with the thermal lid --- observed three flies flying around the kitchen-landing on the pole at end of steamtable and in front of the lowerator. - Interview on 07/30/25 at 12:15 P.M. DM #700 verified the lowerator was dirty and stated they would clean it. 3. Observation on 07/31/25 at 11:04 A.M. of the nursing unit refrigerator and microwave on the D unit with Assistant Director of Nursing (ADON) #502 revealed a towel in the freezer and underneath the towel was a pink/reddish colored stained frost and a blue plastic spoon in the frost. Inside of the refrigerator were towels on each shelf observed various stains on the inside, bottom part of the refrigerator and the inside of the door. The microwave was heavily soiled with various dried stains/food splatters. Interview at this time with ADON #502 verified the above findings. Review of the diet type report dated 07/28/25 revealed all residents in the facility received meals from the kitchen. Review of the policy Equipment, dated September 2017 revealed all foodservice equipment will be clean, sanitary, and in proper working order.		

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: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews, record review and facility policy review, the facility failed to maintain an effective pest control program to prevent flies in the facility. This had the potential to affect all 108 residents residing in the facility. Findings include: Observation on 07/28/25 at 10:25 A.M. in Resident #94 and Resident #67's room revealed six flies on Resident #94 bed. Interview on 07/28/25 at 10:32 A.M. with Housekeeping #607 confirmed observation of flies in Resident #94 and Resident #67's room and said she was not sure why there were flies. Observation and interview on 07/28/25 at 10:35 A.M. in Resident #51's room revealed flies, and he said the flies got bad last week. Observation 07/28/25 at 10:41 A.M. in Resident #102's room revealed flies in the room. Observation on 07/29/25 at 2:46 P.M. revealed flies in room B9 and C7. Observation and interview on 07/29/25 at 2:50 P.M. with Resident #79 and Resident #7 revealed flies in their room. Resident #79 said there were lots of flies, and he held up an electric fly swatter he had. Interview on 07/29/25 at 2:54 P.M. with Licensed Practical Nurse (LPN) #581 confirmed above observation of flies in resident rooms B9 and C7. Observation and interviews on 07/29/25 at 3:02 P.M. through 4:00 P.M. during resident council revealed flies in the activity room during the meeting. Resident #76 revealed flies were a daily problem at the facility, and he made his own fly swatter. Resident #99 revealed he requested his brother bring him a fly swatter. Observation on 07/29/25 at 5:08 P.M. of pest control at the facility. Observation and interview on 07/30/25 at 1:22 P.M. of Resident #115 in his room revealed a fly in the room. Resident #115's son said he had just killed a fly in the room. Observation and interview on 07/30/25 at 1:22 P.M. with Resident #102 revealed flies in her room. Resident #102 said the flies have been bad the past few days. Observation and interview on 07/31/25 at 11:31 A.M. with Resident #94 in his room revealed a fly on his bed. He said they were not better. Resident #94 said the pest control came back and got the fly traps. Observation of two sticky fly traps on wall with no flies on trap. Observation on 08/04/25 at 9:40 A.M. of resident #94 and #67's room revealed flies in the room. Observation and interview on 08/05/25 at 3:10 P.M. with Resident #44 and Resident #85 in their room revealed five flies in the room, with one fly on Resident #44's leg. Resident #85 asked if the surveyor could please help them with the fly problem. Interview on 08/05/25 at 4:00 P.M. with Director of Social Services #553 confirmed flies in Resident #44 and Resident #85's room. Interview on 08/05/25 at 3:30 P.M. with the Administrator that flies were still a problem in multiple rooms and areas. The Administrator stated pest control was coming back out. The Administrator said they have flies because residents open doors to the courtyard to go outside and smoke. Interview and observation on 08/06/2025 at 11:53 A.M. with Resident #44 and Resident #85 in their room revealed the exterminator came in last night, sprayed and put up sticky fly traps. Resident #85 said it seemed better today and they were happy. No flies were observed in the room. Review of the facilities pest control records, dated 07/10/25, revealed routine service and general pest treatment was provided. No documented concerns of house flies. Review of record from 07/29/25 at 4:36 P.M. through 5:04 P.M. revealed treatment for fruit flies and house flies. Comments and Recommendations stated Treatment for fruit flies and house flies in rooms C7 and B9. Low activity seen in both rooms. Baited walls and set two bait stickers in both rooms. Review of record from 08/05/25 at 5:45 P.M. through 6:15 P.M. revealed treatment for house flies. Comments and Recommendations stated treated room B13 for ants with no sightings. Treated perimeter, also treated room C7 for flies. No sighting in there. Also followed up with B9 for flies. Saw two flies total in the unit flying. Re-baited and sanitized drains. Review of the facility policy titled Pest Control, revision date 09/15/21, revealed B. If a problem should develop, the Environmental Services Director will contact the pest control company for an additional visit.		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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. Based on observation, staff interview and facility policy review, the facility failed to maintain a clean and sanitary environment. This affected six (Residents #2, #38, #67, #94, #102, and #116) of 108 residents reviewed for environment. The facility census was 108. Findings include: 1. Observation and interview on 07/31/25 at 11:31 A.M. in Residents #94 and #67's room revealed an unknown liquid on the bathroom floor around the toilet. The bathroom had a strong odor of urine. The flooring around toilet had a black stain around seal of toilet. The walls and ceiling of the bathroom had visible dirt and debris. The toilet was continuously running. Resident #94 stated the toilet was always running and the bathroom always smelled. Interview on 07/31/25 at 11:45 A.M. with Certified Nurse Aide (CNA) #583 confirmed unknown liquid on the floor and she stated Resident #67 urinates on the floor in the bathroom. Interview and observation on 07/31/25 at 12:10 P.M. with Maintenance Director #539 revealed Resident #67 urinates on the bathroom floor. He stated they have new tiles for the bathroom, but they have to shut down the bathroom in the room and have not done that yet. He wiped up the unknown liquid with a white washcloth which revealed a brown yellowish tint but could not confirm if this was dirt from the floor or urine. Observation on 08/04/25 at 9:40 A.M. of Residents #94 and #67's room revealed a strong smell of urine in the bathroom. Interview and observation on 08/05/25 at 9:03 A.M. with CNA #576 in Residents #94 and #67's bathroom revealed a strong smell or urine with urine of the floor in front of the toilet and an unknown brown liquid dripping down the side of the toilet. CNA #576 confirmed observation and cleaned bathroom. 2. Observation on 07/31/25 at 4:41 P.M. of Residents #2 and 102's bathroom revealed unknown liquid on the floor in front and behind the toilet and on the toilet seat with a very strong odor of urine. Interview and observation on 07/31/25 at 4:45 P.M. with Maintenance Director #539 in Residents #2 and 102's bathroom confirmed above finding. He used a white washcloth to wipe up the liquid which was yellow and confirmed it was urine. He had checked the toilets for leaks as well and did not find any. 3. Observation and interview on 08/05/25 at 3:15 P.M. with Resident #38 revealed floor trim unattached to floor and in middle of the bathroom floor. The toilet was running and Resident #38 said it constantly runs. Observation and interview on 08/04/25 at 4:33 P.M. with Licensed Practical Nurse (LPN) #545 of Resident #38 bathroom and confirmed unattached trim and running toilet. 4. Observation and interview on 08/05/25 at 4:04 P.M. of Resident #116 room revealed an extremely strong odor of garbage and stale cigarettes that could be smelled from the hallway. Resident #116 was not aware of what the smell was. Observation and interview on 08/06/25 at 4:04 P.M. with Resident #116 revealed a plastic clear garbage bag filled with clothes on the floor. Resident #116 stated he thinks someone brought them into his room yesterday and they were clean clothes. At this time LPN #581 came into room and confirmed observation of bag of clothes. LPN #581 stated they were dirty clothes and removed them from the room. Review of the facility policy titled Laundry Handling & Processing Policy, last reviewed date of 02/01/25, revealed Employees should collect soiled linens from resident/patient rooms throughout the day. This deficiency represents noncompliance investigated under Complaint Number 1358203 (OH00163378).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure intravenous antibiotics were administered according to physician orders for Resident #99. This affected one (Resident #99) of two residents reviewed for antibiotics. The facility census was 108. Findings include: Review of Resident #99's medical records revealed an admission date of 07/19/24. Diagnoses included Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) and osteomyelitis (bone infection). Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #99 had intact cognition. Review of the care plan dated 07/22/25 revealed Resident #99 was receiving antibiotics for suppressive therapy related to osteomyelitis. Interventions included administering antibiotics per physician orders. Review of the physician orders for July 2025 revealed Resident #99 was ordered Piperacillin (antibiotic) intravenous (IV) 3.375 grams every eight hours for 31 doses with a start date of 07/09/25 and end date of 07/19/25. Review of Treatment Administration Record (TAR) for July 2025 revealed Piperacillin had not been administered on 07/15/25 due to course had been complete. Review of the progress note dated 07/15/25 timed 2:54 P.M. authored by Licensed Practical Nurse (LPN) #545 revealed infectious disease had been contacted and stated Resident #99 had completed his IV antibiotic, and his IV could be removed. Review of the progress note dated 07/21/25 timed 3:53 P.M. authored by LPN #545 revealed Resident #99's IV could be removed, and Resident #99 was to begin oral antibiotics. Interview on 08/05/25 at 11:44 A.M. with LPN #545 revealed she had contacted the infectious disease physician on 07/15/25 and received verbal orders to remove Resident #99's IV and begin him on oral antibiotics. LPN #545 was unable to state who had removed Resident #99's IV; however, LPN #545 stated it had been removed. LPN #545 further stated she had contacted the infectious disease physician again on 07/21/25 to clarify the oral antibiotics and again confirmed Resident #99's IV had been removed on 07/15/25. Review of physician orders with LPN #545 at time of interview confirmed orders for the IV antibiotics to be administered from 07/09/25-07/19/25. LPN #545 was unable to provide an explanation of why Resident #99's IV may have been removed on 07/15/25. Interview on 08/05/25 at 1:35 P.M. with the Director of Nursing (DON) revealed Resident #99's IV had not been removed on 07/15/25, and stated Resident #99 had removed his IV himself on 07/21/25. The DON was unable to provide an explanation for the progress note authored by LPN #545 on 07/15/25 that indicated the IV had been removed, and the resident was to begin oral antibiotics. The DON further was unable to provide an explanation regarding antibiotics not being administered on 07/15/25 due to course had been completed. The DON further confirmed no documentation related to Resident #99's IV removal.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, observation and interview, the facility failed to ensure the correct serving sizes were served for the pureed diet. This affected 10 (Residents #14, #33, #36, #64, #71, #82, #84, #86, #91, and #105) who received a pureed diet. The facility census was 108. Findings include: Observation on 07/30/25 at 11:17 A.M. of the tray line for lunch meal service revealed that pureed chicken was served using the #10 ivory handled scoop, and the pureed rice was served using the #12 green handled scoop. Review of the menu and diet guide sheet for lunch on 07/30/25 revealed pureed chicken should be served using the #8 scoop (grey handled scoop) and the pureed rice should be served using the #10 scoop (ivory handled scoop). Review of the disher and scoop size chart revealed the #8 scoop was a grey handled scoop that provided four ounces; the #10 scoop was an ivory handled scoop that provided 3.25 ounces; and the #12 scoop was a green handled scoop that provided 2.66 ounces. Interview on 07/30/25 at 12:45 P.M. with Dietary Manager (DM) #700 verified the scoops used to serve the pureed chicken and pureed rice were not correct scoops according to the menu and diet guide. Reviewed diet type report dated 07/28/25 revealed 10 (Residents #14, #33, #36, #64, #71, #82, #84, #86, #91, and #105) received a pureed diet.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the failed to ensure an as needed (PRN) psychotropic medication had a stop date for Residents #9 and #107. This affected two (Residents #9 and #107) of five residents reviewed for unnecessary medications. The facility census was 108. Findings include:1. Review of the medical record revealed Resident #9 was admitted on [DATE] with diagnoses including Parkinson's disease, dementia, psychotic disorder with hallucinations, visual hallucinations, auditory hallucinations, delusional disorders, anxiety, major depressive disorder, chronic obstructive pulmonary disease, emphysema, asthma, hypertensive chronic kidney disease, atherosclerotic heart disease, hyperlipidemia, iron deficiency anemia, adjustment disorder, post-traumatic stress disorder, nightmare disorder, chest pain, obesity, osteoarthritis, vitamin d deficiency, and dysphagia. Review of the physician order dated 06/28/25 revealed active orders for Ativan oral tablet 0.5 milligrams (mg) (Lorazepam) (antianxiety) every six hours PRN for anxiety with no stop date. Review of the June 2025 Medication Administration Record (MAR) revealed Resident #9 received the PRN Ativan every day since 06/28/25 for a total of five times. Review of the July 2025 MAR revealed Resident #9 received the PRN Ativan every day in July except on 07/03/25, 07/18/25, and 07/28/25 for a total of 47 times. Review of the August 2025 MAR revealed Resident #9 received the PRN Ativan every day for a total of 10 times as of 08/07/25. Review of the Consultant Pharmacist Review dated 07/15/25 revealed no apparent medication irregularities noted at this time. Interview on 08/08/25 at 12:13 P.M. with the Administrator verified there was no stop date for the PRN Ativan order with a start date of 06/28/25. 2. Review of the medical record for Resident #107 revealed an admission date of 11/30/22. Diagnoses included end stage renal disease, dependence on renal dialysis, congestive heart failure, type two diabetes mellitus, Alzheimer's disease, dementia, and anxiety disorder. Review of the physician orders for August 2025 revealed active orders for Ativan oral tablet one mg. Give one tablet by mouth every eight hours PRN for anxiety with a start date of 07/02/25. Review of the July 2025 MAR revealed Resident #107 received the PRN Ativan every day since start date of 07/02/25 except on 07/14/25, 07/23/25, 07/24/25, and 07/29/25. Review of the August 2025 MAR revealed Resident #107 received the PRN Ativan on 08/01/25, 08/02/25, 08/03/25, 08/04/25, and 08/05/25. Interview on 08/05/25 at 1:38 P.M. with the Director of Nursing (DON) verified there was no stop dated to the PRN Ativan order with the start date of 07/02/25.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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, observation, interview and facility policy review, the facility failed to ensure Residents #22, who was dependent on staff for personal hygiene, was provided adequate and timely nail care. This affected one (Resident #22) of two residents reviewed for activities of daily living. The facility census was 108. Findings include: Review of Resident #22's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following nontraumatic hemorrhage affecting right dominant side, hypertensive heart and chronic kidney disease without heart failure with stage five chronic kidney disease, end-stage renal disease (ESR), heart disease, anemia, dialysis, asthma, cirrhosis of liver, ascites, dysphagia, Barrett's esophagus without dysplasia, acute respiratory failure, acquired absence of stomach, anxiety disorder, type II diabetes and hypotension. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #22 was dependent on staff for personal hygiene. Observation and interview on 07/28/25 at 4:25 P.M. with Resident #22 revealed he had long and unclean fingernails. Resident #22 stated he would like his nails cut. Interview on 07/28/25 at 4:30 P.M. with Licensed Practical Nurse (LPN) #551 informing him that Resident #22 would like his nails cut and cleaned. Interview on 08/08/25 at 12:13 P.M. with Administrator revealed they do not document nail care, and there was no specific staff member assigned to nail care. Review of the undated facility policy titled Nail and Hair Hygiene Services revealed Routine care also includes nail hygiene services including routine trimming, cleaning and filing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to identify maggots in Resident #5's wound. This affected one (Resident #5) of two residents reviewed for wound care. The facility failed to ensure blood pressure medication was administered according to physician orders for Resident #5. This affected one (Resident #5) of three residents observed for medication administration. The facility failed to ensure Resident #54's chole drain dressing was performed according to physician orders. This affected one (Resident #54) of one resident observed for chole drain dressings. The facility census was 108. Findings include: 1. Review of Resident #5's medical records revealed an admission date of 09/04/24. Diagnoses included congestive heart failure, chronic obstructive pulmonary disease, dementia and diabetes. Review of the physician orders dated 05/06/25 through 05/16/25 revealed to cleanse Resident #5's toes on the right foot, apply betadine (antiseptic) in between toes daily and as needed. Review of the current physician orders for July 2025 revealed Resident #5 was ordered metoprolol (blood pressure medication) 50 milligrams (mg) one time a day. Orders included to hold medication if systolic blood pressure reading was below 110 or if heart rate was below 60. Review of the progress note dated 05/19/25 timed 6:19 A.M. authored by Director of Nursing (DON) revealed Resident #5 had increased drainage, redness and swelling along with increased pain to legs. The physician was contacted, and orders were received to send Resident #5 to the hospital. Review of the podiatry progress note dated 05/20/25 revealed Resident #5 had stated they do not take good care of her wounds at the facility. The progress note further stated Resident #5 was unaware she had maggots in her wounds. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 was dependent on staff with toileting, bathing and personal hygiene. Review of the care plan dated 07/12/25 revealed Resident #5 was at risk for altered skin integrity. Interventions included administer treatments as ordered, complete weekly skin checks, encourage resident to elevate feet at intervals during the day, and evaluate existing wound daily for changes. Telephone interview on 07/28/25 at 11:24 A.M. with Resident #5's daughter revealed she was informed by the hospital during her admission in May 2025 that Resident #5 had maggots in her wounds. Resident #5's daughter stated she felt the facility had not been caring for her wounds daily as required and stated the maggots had developed due to neglect from the facility. Observation of medication administration on 07/29/25 at 7:30 A.M. with Licensed Practical Nurse (LPN) #503 revealed she had popped Resident #5's metoprolol from a medication card. The medication card had instructions on the top that stated to hold medication if systolic blood pressure was below 110 or heart rate below 60. LPN #503 did not obtain a blood pressure or heart rate prior to administering metoprolol. Interview with LPN #503 at the time of the observation confirmed she had not obtained blood pressure reading or heart rate prior to administering the medication. Interview on 08/06/25 at 1:05 P.M. with the DON revealed she had not been aware Resident #5 had maggots in her wound. Review of Resident #5's Treatment Administration Record (TAR) for May 2025 with DON at the time of the interview confirmed treatments had been documented as having been completed, with no documented refusals of treatments. Review of the podiatry note dated 05/20/25 with the DON at the time of interview confirmed documentation of maggots in Resident #5's wound. 2. Review of Resident #54's medical records revealed an admission date of 01/06/25. Diagnoses included malnutrition and Alzheimer's. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #54 had impaired cognition. Review of the current physician orders for July 2025 revealed to cleanse Resident #54's chole site with normal saline and cover with a drain sponge daily and as needed. Review of the TAR for July 2025 revealed Resident #54's chole dressing changes had been documented daily as ordered. Observation on 07/28/25 at 1:05 P.M. with LPN #503 revealed Resident #54 had a silicone dressing to her chole site. Interview with LPN #503 at time of observation revealed she was unaware of what dressing had been ordered. Interview on 08/05/24 at 1:35 P.M. with the (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON confirmed Resident #54's physician orders were for a gauze dressing; however, the silicone dressing was in place at time of observation. Review of Resident #54's TAR for July 2025 with the DON at the time of the interview revealed the documentation on the TAR indicated a gauze dressing had been completed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER The Colony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Colony Park Drive Tallmadge, OH 44278	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure intravenous antibiotics were administered according to physician orders for Resident #99. This affected one (Resident #99) of two residents reviewed for antibiotics. The facility census was 108. Findings include: Review of Resident #99's medical records revealed an admission date of 07/19/24. Diagnoses included Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) and osteomyelitis (bone infection). Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #99 had intact cognition. Review of the care plan dated 07/22/25 revealed Resident #99 was receiving antibiotics for suppressive therapy related to osteomyelitis. Interventions included administering antibiotics per physician orders. Review of the physician orders for July 2025 revealed Resident #99 was ordered Piperacillin (antibiotic) intravenous (IV) 3.375 grams every eight hours for 31 doses with a start date of 07/09/25 and end date of 07/19/25. Review of Treatment Administration Record (TAR) for July 2025 revealed Piperacillin had not been administered on 07/15/25 due to course had been complete. Review of the progress note dated 07/15/25 timed 2:54 P.M. authored by Licensed Practical Nurse (LPN) #545 revealed infectious disease had been contacted and stated Resident #99 had completed his IV antibiotic, and his IV could be removed. Review of the progress note dated 07/21/25 timed 3:53 P.M. authored by LPN #545 revealed Resident #99's IV could be removed, and Resident #99 was to begin oral antibiotics. Interview on 08/05/25 at 11:44 A.M. with LPN #545 revealed she had contacted the infectious disease physician on 07/15/25 and received verbal orders to remove Resident #99's IV and begin him on oral antibiotics. LPN #545 was unable to state who had removed Resident #99's IV; however, LPN #545 stated it had been removed. LPN #545 further stated she had contacted the infectious disease physician again on 07/21/25 to clarify the oral antibiotics and again confirmed Resident #99's IV had been removed on 07/15/25. Review of physician orders with LPN #545 at time of interview confirmed orders for the IV antibiotics to be administered from 07/09/25-07/19/25. LPN #545 was unable to provide an explanation of why Resident #99's IV may have been removed on 07/15/25. Interview on 08/05/25 at 1:35 P.M. with the Director of Nursing (DON) revealed Resident #99's IV had not been removed on 07/15/25, and stated Resident #99 had removed his IV himself on 07/21/25. The DON was unable to provide an explanation for the progress note authored by LPN #545 on 07/15/25 that indicated the IV had been removed, and the resident was to begin oral antibiotics. The DON further was unable to provide an explanation regarding antibiotics not being administered on 07/15/25 due to course had been completed. The DON further confirmed no documentation related to Resident #99's IV removal.		