| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366010 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Pinnacle Rehabilitation and Nursing Center | 330 Southwest Ave<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, manufactures guidelines and policy review, the facility failed to ensure Resident #13 rinsed her mouth after using a steroid inhaler. This affected one (Resident #13) of three residents observed for use of steroid inhalers. This also had the potential to affect seven (Residents #4, #9, #12, #33, #43, #59, and #87) identified by the facility as also receiving steroid inhaler treatments.Findings include:Review of the medical record for Resident #13 noted an admission date of 01/21/26. Diagnoses included obstructive pulmonary disease, unspecified asthma, and chronic respiratory failure with hypercapnia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had intact cognition. Observation on 03/09/26 at 8:02 A.M. of medication administration noted Licensed Practical Nurse (LPN) #404 administering medications to Resident #13. LPN #404 handed Resident #13 an Advair Diskus steroid inhaler, Resident #13 took one breath and gave the inhaler back to LPN #404. LPN #404 did not encourage or prompt Resident #13 to rinse her mouth after inhaling the steroid. During an interview with LPN #404 immediately after the observation, LPN #404 stated [Resident #13] did not like water, so I did not say anything. LPN #404 then stated, I know residents should rinse their mouths with some inhalers, but I am not sure. During an interview on 03/11/26 at 9:35 A.M., Director of Nursing (DON) verified staff should be encouraging residents to rinse their mouths after using a steroid inhaler.Review of the Advair Diskus inhaler guidelines from accessdata.fda.gov, noted after inhalation, the resident should rinse his/her mouth with water without swallowing to help reduce the risk of overgrowth of yeast in the mouth (oropharyngeal candidiasis).Review of the undated facility policy titled Administering Medications through a Metered Dose Inhaler noted staff should provide a gargling solution when administering an inhaler. The policy did not provide direction for staff to encourage residents to rinse their mouths after using a steroid inhaler. Review of the facility policy titled Administering Medications through a Metered Dose Inhaler, dated 2001, noted staff should provide a gargling solution when administering an inhaler. The policy did not provide direction for staff to encourage residents to rinse their mouths after using a steroid inhaler. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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