

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Tallmadge Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 619 Northwest Avenue 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, review of a self-reported incident (SRI) investigation and staff interviews, the facility failed to ensure Resident #81 was appropriately secured during a wheelchair transport resulting an unsafe transfer of the resident. This finding affected one (Resident #81) of three residents reviewed for falls.</p> <p>Findings include:</p> <p>Review of Resident #81's closed medical record revealed the resident was admitted on [DATE] with diagnoses including muscle weakness, essential hypertension and acute kidney failure.</p> <p>Review of Resident #81's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.</p> <p>Review of Resident #81's Neglect SRI tracking #241553 dated 11/27/23 revealed the resident was transported to her dentist appointment via a facility van and hit her head during the transport. She denied injuries. The SRI was unsubstantiated.</p> <p>Review of Resident #81's progress note dated 11/27/23 at 7:00 P.M. authored by Licensed Practical Nurse (LPN) #819 indicated the resident was admitted to the hospital due to a head injury which happened during transport to an appointment.</p> <p>Review of Resident #81's Cat Scan (imaging technique that uses X-rays and a computer to create detailed images of the inside of the body) of the head without contrast dated 11/27/23 at 2:57 P.M. revealed no evidence of an acute intracranial process and no evidence of an acute intracranial hemorrhage.</p> <p>Review of Resident #81's progress note dated 11/28/23 at 9:21 A.M. authored by Registered Nurse (RN) #820 indicated the resident was admitted with a diagnoses of acute kidney injury. The cat scan of the head was unremarkable.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #81's progress note dated 12/07/23 at 6:10 P.M. revealed the resident was discharged from the hospital and arrived at the facility at 6:10 P.M. via a stretcher.</p> <p>Interview on 05/15/24 at 11:38 A.M. with Transport Driver #821 revealed he was scheduled to take Resident #81 to the dentist's office and the son was to meet him there. He stated he secured the resident in her wheelchair in the transport van and drove to the dentist's office. He stated he pulled into the driveway and opened the van door and unsecured the resident to remove her from the van. The resident's son came up to him and stated he was in the wrong driveway. Transport Driver #821 indicated he shut the door and drove to the other driveway about ten feet from his original position without securing the resident in the transport van. Transport Driver #821 revealed Resident #81's wheelchair tipped backward and she reported she hit her head on the van door. He stated he was terminated because of the incident, and he did not have a reason why he did not secure the resident during the transport from one driveway to the adjacent driveway. He confirmed he was educated on transporting residents.</p> <p>Interview on 05/15/24 at 12:55 P.M. with the Medical Director revealed he was aware Resident #81 hit her head during a transport to the dentist's office. The Medical Director indicated he reviewed the emergency room paperwork which did not mention anything about injuries to the resident's head.</p> <p>Interview on 05/15/24 at 2:00 P.M. with RN Clinical Specialist #816 stated the facility fired the transport driver, completed an SRI investigation on the incident, educated staff members on safe transports, did an inspection on securement devices on van, interviewed all residents who utilized van in last month to make sure was secured, stopped using van for a short time and used outside contractors due to this incident and conducted audits on safe securement during resident transport.</p> <p>Review of the Transport policy revised 03/13/24 revealed all drivers would aid in the safe entry and exit of residents from the facility vehicles and provide a safe journey to and from their destination.</p> <p>The deficiency was corrected on 11/28/23 when the facility implemented the following corrective actions:</p> <p>On 11/27/23, the facility suspended Transport Driver #821 and subsequently issued a termination on 12/05/23 following the improper transport of Resident #81.</p> <p>On 11/27/23, the facility filed a Neglect SRI tracking #241553 and conducted an investigation regarding the transport incident involving Resident #81 which the facility unsubstantiated.</p> <p>On 11/27/23, Activity Director #806 (the remaining facility transport driver) was re-educated on safe driving techniques including resident securement.</p> <p>On 11/28/23, an inspection was completed of the transport van to make sure the equipment to secure residents was intact.</p> <p>On 11/28/23, Residents #11, #30, #39, #41, #44, #82 and #83 were interviewed to ensure they were secured during transport.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Outside transportation was utilized from 11/28/23 to 01/31/24 due to a lack of a transportation driver.</p> <p>Audits were conducted weekly times four weeks and then monthly times two months to ensure safe resident transport.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153648.</p>		