

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 12/19/2024
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 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on record review, review of hospital documentation, review of staff schedules, staff interview and policy review, the facility failed to develop and implement a comprehensive and effective pain management program for Resident #90, at the time of admission including adequate and accurate assessment and administration of physician ordered pain medication resulting in a re-hospitalization for the resident due to unrelieved pain.</p> <p>Actual harm occurred on 08/16/24 following Resident #90's admission to the facility for post-operative care when the resident experienced excruciating pain, was yelling out in pain and requesting pain medication that was not timely addressed. The resident was subsequently transferred to the hospital and readmitted due to abdominal pain.</p> <p>This affected one resident (#90) of three residents reviewed for pain management. The facility census was 75.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #90 revealed and admitted [DATE] and a discharge date of [DATE]. Diagnoses included diverticulitis of large intestine with perforation and abscess without bleeding, unspecified abdominal pain, need for assistance with personal care, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of Resident #90's hospital discharge summary dated 08/16/24 revealed the resident was discharged from the hospital after having perforated diverticulitis, an exploratory laparotomy (a surgical incision into the abdominal cavity for diagnosis or in preparation for surgery) was completed as well as a sigmoid colectomy (a surgical procedure to remove the sigmoid colon, the lower part of the large intestine that connects to the rectum) and an end sigmoid colostomy (a surgical procedure that creates an opening in the abdominal wall for stool to drain through). The procedures were completed on 07/23/24 and a wound vacuum (a treatment used to help wounds heal) was removed on 08/14/24. The resident had a wound in his abdomen that required wet to dry dressing changes twice daily. He was discharged with an order for pain medication, Oxycodone immediate release (IR) 5 milligram (mg) tablet with instructions to take a half tablet or a whole tablet by mouth every six hours as needed for up to five days. The prescription was sent to the facility.</p> <p>Review of the admission assessment dated [DATE] revealed Resident #90 was alert and generally oriented to person, place, and time. His memory was intact and his thinking was clean and organized.</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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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Resident #90's physician's orders revealed an order dated 08/16/24 for Oxycodone five mg with instructions to take one tablet by mouth every six hours as needed for pain for up to five days and an order to cleanse the residents midline abdomen with normal saline, pat dry, pack the wound bed, apply normal saline moistened gauze, and cover with an abdominal (ABD) pad twice a day and as needed.</p> <p>Review of Resident #90's Medication Administration Record (MAR) revealed he did not receive any pain medications while at the facility (08/16/24 and 08/17/24). The record documented on dayshift (7:00 A.M. to 7:00 P.M.) his pain was rated a four and nightshift (7:00 P.M. to 7:00 A.M.) pain was a 0.</p> <p>Review of Resident #90's Physical Therapy (PT) evaluation and plan of treatment dated 08/16/24 revealed the resident's pain level was determined based upon behaviors exhibited by the patient and behaviors were exhibited; The note revealed the resident reported abdominal discomfort and the nurse was aware.</p> <p>Review of Resident #90's progress notes revealed a Nurse Practitioner note dated 08/16/24 at 1:56 P.M. indicating the resident was being admitted due to a perforated sigmoid colon, he was colostomy status, and had an abdominal wound. The note revealed to continue wound care, colostomy care, and to give Oxycodone for pain. The note indicated the resident was being seen and examined in his room, he was alert and oriented times two to three, and he was very frail and cachectic looking. The resident had just arrived from the hospital with his wife, he reported pain and discomfort in the belly, denied nausea and vomiting, and stated he could tolerate regular food. Continued review of notes revealed the next progress note on 08/17/24 at 9:05 A.M. indicated the resident was sent to the hospital via ambulance per patient and family request.</p> <p>Review of Resident #90's emergency room and admission paperwork dated 08/17/24 at 9:40 A.M. and discharge on 08/21/24 revealed the resident was readmitted with abdominal pain. The emergency room report revealed Resident #90 had abdominal pain and a wound dressing and kept calling 911. He presented to the emergency department for evaluation of abdominal pain and requesting a new nursing/rehabilitation facility. He was recently admitted (to the hospital) for perforated viscus and was discharged (to the nursing home) with instructions to do wet-to-dry dressings twice a day. According to the resident, the rehabilitation facility did not change his dressing since he had been there. He was also endorsing abdominal pain all over his abdomen. The report revealed the resident received Hydromorphone 0.5 mg intravenous on 08/17/24 at 10:29 A.M. and the follow up pain assessment at 10:51 A.M. was a three out of ten (a pain scale from zero to 10 with a zero being no pain and a 10 being the worst pain).</p> <p>Review of the staffing schedule for 08/16/24 revealed Licensed Practical Nurse (LPN) #110, Certified Nursing Assistant (CNA) #112, and Registered Nurse (RN) #113 were all assigned to the 300 hall where Resident #90's room was located between the hours of 7:00 P.M. until 7:00 A.M.</p> <p>Interview on 12/18/24 at 11:56 A.M. with RN #113 (the nurse assigned to Resident #90 on 08/16/24 from the hours of 2:00 P.M. until 7:00 P.M.) reported she could not recall the resident or being told of his pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/18/24 at 2:00 P.M. with Clinical Quality Specialist Registered Nurse (CQSRN) #107 reported Resident #90 was admitted to the facility around 2:00 P.M. on 08/16/24. She stated he came with a prescription for Oxycodone 5 mg. She stated they faxed the prescription and got an authorization for the medication a little after 7:00 P.M. that night. She stated that only one nurse had access to their Omnicell (a machine where the medication is kept onsite) so she was unable to pull the medication for the resident (as two nurses accesses were needed to access the medication). She revealed she spoke with LPN #110 who stated she gave the resident Tylenol at some point that night, but confirmed it was not documented. CQSRN #107 reported Resident #90 contacted EMS services during the night and eventually in the morning he was transported to the hospital due to complaints of pain. She verified the resident was not properly assessed for pain, documentation was not completed regarding the incident, and he was not given as ordered pain medication after experiencing pain throughout the night due to issues with the onsite emergency medication access. She reported it would be her expectation that the Director of Nursing (DON) would come into the facility and pull the medication for the resident.</p> <p>On 12/18/24 at 2:47 P.M. a telephone interview with LPN #110 reported she was assigned to Resident #90 on the night of 08/16/24 from 7:00 P.M. until 7:00 A.M. She reported she was told the resident had an abdominal wound and had been medicated (for pain) shortly before his arrival to the facility. LPN #110 stated shortly after she arrived at work, the resident began to request pain medication and had rated his pain at a five or six (on a scale of one to 10). She went on to say she told him she was unable to access the medication, and he would need to wait until the shipment of medications came in. The LPN stated the resident's vital signs were stable so she did not feel the situation was urgent. She stated although they had the medication at the facility and an authorization from the pharmacy to pull the medication, only one nurse in the building had access to the supply and two nurses were needed to pull the medication together. The nurse went on to say throughout the night the resident's pain increased, he ripped off his dressing and yelled out requesting medication for pain and to be transported to the emergency department. The nurse stated the resident called EMS several times throughout the night and eventually he was transferred and admitted to the hospital in the morning. She went on to say she contacted the DON after the resident's wife became upset at the facility for not treating the resident's pain and the DON relayed that if the resident's wife had pain medication, she could bring it in. LPN #110 stated before the resident's wife could get to the facility with the pain medication, EMS was already there to transport the resident back to the hospital. She stated the next day the DON and Assistant Director of Nursing (ADON) #102 asked her to come in and make a statement regarding the incident, which she did. When asked why she documented the resident's pain at a zero for her shift she stated she did not know why and she thought she made a detailed progress note regarding the situation.</p> <p>On 12/18/24 at 3:18 P.M. a telephone interview with Certified Nursing Assistant (CNA) #112 revealed she was assigned to Resident #90 on 08/16/24 from 7:00 P.M. until 7:00 A.M. She reported when she arrived for her shift, the resident was agitated because his pain medication was not at the facility. She reported the resident was pushing his call light throughout the night stating he was in pain, he was yelling out and looked pretty sickly. CNA #112 reported she kept telling LPN #110 the resident was in pain and LPN #110 reported to the resident that the medication would not be available until the morning. CNA #112 reported the resident called 911 several times due to pain and wanted to be transported to the hospital. She stated EMS did eventually take the resident to the hospital in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/19/24 at 9:10 A.M. a telephone interview with Assistant Director of Nursing (ADON) #102 revealed she recalled having LPN #110 come back into the facility to make a statement after speaking to Resident #90's wife in relation to the above incident. ADON #102 reported the resident's wife was very upset regarding her husband not receiving any pain medication throughout the night. ADON #102 reported after the statement was collected it would have been up to the DON to complete the investigation into the concerns. Additionally, ADON #102 reported the the facility did have an issue with getting their nurses into the system so they could pull from the emergency medication supply (Omnnicell).</p> <p>Interview on 12/19/24 at 9:20 A.M. with the Administrator revealed there were no statements regarding the situation with Resident #90 and she could not recall the incident.</p> <p>Information obtained from Resident #90 as part of the complaint investigation revealed Resident #90 was transported from the hospital to the facility on [DATE] with a large open (abdominal) wound. The resident arrived at the facility at approximately 2:00 P.M. and stated he had last received pain medication around 12:00 P.M. the same day while at the hospital. Upon arrival, the resident was informed the facility did not have a pharmacy on site and the medication would need to come from an outside pharmacy. The resident revealed on 08/16/24 by 11:00 P.M. he was in excruciating pain and he called emergency services to see if they could transfer him out of the facility. The resident's wife was able to contact the on-call doctor and was told to arrange transportation back to the ER immediately. The resident was transported to the Emergency Department (ED) on 08/17/24 at around 10:00 A.M. The resident revealed the first thing the emergency department did was medicate him for pain. The resident stated he was hospitalized for another five days following this admission.</p> <p>Review of the facility policy, Pain Management, revision date 08/01/24 revealed it was the policy of the community to ensure any resident admitted to the facility was assessed for pain and or potential for pain, for the resident to reach and maintain his/her highest practicable level of physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care. A pain evaluation would occur on admission to the facility, at each quarterly review, with significant change in condition, and with any onset of new pain.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160260.</p>		