STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366487	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallmadge Health & Rehab Center	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)
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. (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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, hospital record review, and interview, the facility failed to ensure Resident #39 received proper care and assistance in managing his ostomy and tube feed needs. This affected one resident (Resident #39) of three residents reviewed for dependent resident care.Findings include:Review of Resident #39's medical record revealed an admission date of 03/31/25 and a return date of 08/31/25. Resident #39's diagnoses included acute and chronic respiratory failure with hypoxia, Rett's syndrome, Todd's paralysis (post epileptic), and epileptic seizures related to external causes, not intractable, with status epilepticus.Review of Resident #39's Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status was not completed because he was rarely or never understood. Resident #39 was dependent for activity of daily living (ADL), the ability to roll from lying on his back to the left and right side and return to lying on back on the bed, and chair-to-bed-to-chair transfers. Resident #39 had a wheelchair. Resident #39 had a catheter and an ostomy. Resident #39 had medically complex conditions. Review of Resident #39's care plan revised 08/12/25 revealed Resident #39 had self-care deficits related to acute and chronic respiratory failure, seizure disorder and other diagnoses. Resident #39's needs would be met through the next review. Interventions included Resident #39 was dependent on two staff and used a mechanical lift; last check and change on last rounds on night shift.Review of Resident #39's Enteral Administration History dated 08/01/25 through 08/31/25 revealed enteral feeding tube site care, once a day, clean tube feeding site and apply split gauze to area daily was documented it was completed every day as ordered including 08/31/25. Review of Resident #39's nursing orders dated 08/05/25 revealed orders for skin checks weekly and as needed.Review of Resident #39's physician orders dated 08/05/25 revealed orders for Calmoseptine (menthol-zinc oxide) 0.44 -20.6 percent, apply to GJ (gastrojejunostomy) irritation as needed. Review of Resident #39's nursing orders dated 08/05/25 revealed orders to change colostomy skin barrier appliance (wafer) as needed for leakage or detachment.Review of Resident #39's nursing orders dated 08/05/25 revealed orders to change colostomy bag, pouch and set up as needed.Review of Resident #39's nursing orders dated 08/05/25 revealed orders to monitor stoma site and peristomal skin every shift, monitor for redness, tenderness, itching, burning, and, or swelling. Report changes to provider and document in a note, every day shift and night shift.Review of Resident #39's progress notes dated 08/26/25 through 08/31/25 did not reveal evidence Resident #39's right lower abdominal area was very red and irritated. Review of Resident #39's Treatment Administration History dated 08/26/25 revealed the weekly skin check was marked it was done but there was no evidence a weekly skin check observation was completed.Review of Resident #39's Treatment Administration History dated 08/31/25 revealed there was no evidence Resident #39's colostomy skin barrier appliance was changed due to it being detached from the ostomy. There was no evidence Resident #39's colostomy bag, pouch and set-up was changed due to it being detached from the ostomy.Review of Resident #39's Treatment Administration History dated 08/05/25 through 08/31/25 did not reveal evidence Calmoseptine ointment was applied for GJ irritation.Review of the facility assignment sheets dated 08/31/25 from 7:00 A.M. through 7:00 P.M. revealed Nurse #229 was assigned to care for Resident #39.Review of Resident #39's Treatment Administration History dated 08/31/25 on day shift documented by Nurse #229 revealed Resident #39's stoma site and peristomal skin did not have redness, tenderness, itching, burning or swelling. Review of Resident #39's progress notes dated 08/31/25 at 9:35 A.M. revealed the respiratory therapist (RT) called Nurse #229 to Resident #39's room. Nurse #229 found Resident #39's tube (G-tube) was out and he needed to go to the local hospital ED for a new tube.Review of Resident #39's progress notes dated 08/31/25 at 9:35 A.M. through 08/31/25 at 10:33 A.M. did not reveal evidence Resident #39's ostomy bag was detached from his ostomy site and needed replaced. There was no evidence Resident #39's tube feeding was draining onto Resident #39 and the floor of his room.Review of Resident #39's progress notes dated 08/31/25 at 10:33 A.M. revealed Resident #39 was transported via EMS to the ED.Review of Resident #39's hospital ED progress notes dated 08/31/25 at 11:41 A.M. revealed Resident #39 arrived at the hospital ED via EMS from the facility. It was reported that Resident #39's G-tube was out and the facility was unaware when it became dislodged. The EMS staff stated when they arrived at the facility Resident #39 was covered in feed from the feeding tube and no ostomy bag was on the ostomy. The EMS staff asked the facility to place a bag on the ostomy and Resident #39 arrived at the hospital ED with an ostomy bag laid on top of the ostomy and the ostomy bag was not attached. The bag was not attached to the

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(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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, policy review and interview the facility failed to develop and implement a comprehensive and individualized pressure ulcer program to ensure necessary and timely interventions were initiated for Resident #96 who was identified to have skin breakdown in the hospital just prior to admission. The facility also failed to timely identify changes in skin integrity and implement necessary wound care to promote wound healing and prevent infection.Actual harm occurred on 07/31/25 when Resident #96, who was dependent on staff for activities of daily living, was transferred to the hospital due to a change in condition. The resident was subsequently assessed by hospital staff to have an unstageable sacral wound with a significant amount of purulence in the tissue consistent with a necrotizing soft tissue infection. Hospital staff also documented the resident had a pressure injury to the right buttock, a pressure injury to the right heel (assessed to be black), a pressure injury to the upper posterior right leg (assessed to be a suspected deep tissue pressure injury). Prior to the hospital identification and assessment, there was no evidence the facility had knowledge of these areas or an active treatment plan in place to prevent, monitor and promote healing. This affected one resident (#96) of three residents reviewed for wound/pressure ulcers.Findings include:Review of Resident #96's medical record revealed an After Visit Summary for a hospital stay from 06/30/25 through 07/08/25 that reflected Resident #96 had a coccyx (active) pressure injury (identified on 07/05/25). On 07/06/25 the coccyx pressure area was non-blanchable (skin discoloration that did not fade or turn white when pressed, indicating bleeding under the skin rather than increased blood flow. This type of discoloration was a significant clinical sign that required immediate medical attention, as it could signal developing pressure injuries), had erythema (abnormal redness of the skin, caused by dilation and irritation of the superficial capillaries), sloughing (sloughing in pressure injuries referred to the presence of dead tissue, appearing as yellow, tan, gray, or green stringy material that covered the wound bed. This tissue consisted of protein fibers and dead skin cells and impeded healing by obscuring the wounds true depth and staging) and was pink. The peri-wound was blanchable, had erythema and was fragile. The hospital record noted treatment to the coccyx pressure area included cleansing, a moisture barrier ointment and foam dressing. Review of Resident #96's closed medical record revealed an admission date of 07/08/25 with diagnoses including malignant neoplasm of the ascending colon, secondary neoplasm of the liver and intrahepatic bile duct, severe protein calorie malnutrition and type two diabetes mellitus with diabetic polyneuropathy. On 07/31/25 Resident #96 was transported to the hospital emergency department (ED), admitted to the hospital and did not return to the facility. Review of Resident #96's facility admission Observation dated 07/08/25 at 6:19 P.M. documented Resident #96 had no alterations in skin. The admission observation failed to include identification of the pressure injury to the resident's coccyx identified on 07/05/25 during the resident's hospitalization or treatment that was in place to the area. Resident #96's Braden Scale assessment dated [DATE] revealed the resident was at high risk for developing pressure ulcers, injuries.Review of Resident #96's care plan dated 07/08/25 included Resident #96 was at risk for pressure ulcers related to his diagnoses. The goal developed was for Resident #96's skin to remain intact. Interventions included to conduct a systematic skin inspection weekly and as needed (pay particular attention to the bony prominences) and report signs of skin breakdown (sore, tender, red, or broken areas). The plan of care failed to include evidence of the pressure injury to the resident's coccyx identified on 07/05/25 during the resident's hospitalization or evidence ongoing treatment was in place to the area. Review of Resident #96's Weekly Observation dated 07/08/25 revealed there were no skin issues noted. Review of Resident #96's Observations dated 07/08/25 through 07/31/25 did not reveal evidence additional Weekly Observations were completed. In addition, review of the Observations dated 07/08/25 through 07/31/25 revealed no evidence Assistant Director of Nursing (ADON) #275 had completed a skin assessment during this time.Review of Resident #96's physician orders dated 07/08/25 revealed pressure reducing/reduction orders to float heels when in bed as tolerated, every shift (day shift and night shift). Provide pressure reducing cushion to chair and document cushion in place in the chair. Provide pressure reducing mattress to the bed and document that mattress was in place. Turn and reposition in bed as tolerated every shift, every day shift and night shift. Review of Resident #96's medical record including progress notes, General Administration Records, Treatment Administration Records, Medication Administration Records and Point of Care aide charting dated 07/08/25 through 07/31/25 revealed no