

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  10/16/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure Resident #2's gastric tube was properly assessed, monitored, and cared for. This affected one resident (Resident #2) out three residents reviewed for feeding tubes. Findings include: Review of medical record for Resident #2 revealed an admission date of 08/28/25 with diagnosis included but not limited to, chronic respiratory failure, other artificial openings of gastrointestinal tract status, type 2 diabetes mellitus with diabetic neuropathy, severe protein-calorie malnutrition, gastrostomy infection, end stage renal disease, dependence on renal dialysis, dependence on respirator, and tracheostomy status. Review of the care plan dated 09/02/25 and last revised 09/11/25 revealed Resident #2 was at nutrition risk related to gastric tube related to chronic respiratory failure on ventilator, tracheostomy, and end stage renal disease (ESRD) on dialysis. Goal to include Resident #2 will be free of complications related to presence of feeding tube daily. Intervention to include provide tube site care per physician order and facility policy. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had intact cognition. Resident #2 was dependent for activities of daily living (ADL) care. Review of the care plan dated 09/02/25 and last revised 09/11/25 revealed Resident #2 was at nutrition risk related to gastric tube related to chronic respiratory failure on ventilator, tracheostomy, and end stage renal disease (ESRD) on dialysis. Goal to include Resident #2 will be free of complications related to presence of feeding tube daily. Intervention to include provide tube site care per physician order and facility policy. There was no evidence of readmission on [DATE] care plan for feeding tube care. Review of the progress note dated 10/07/25 at 7:29 A.M. revealed Resident 2 had two episodes of emesis, the physician was notified and ordered to send the resident to hospital for evaluation. Review of the progress note dated 10/12/25 at 6:00 P.M. revealed Resident #2 was readmitted to facility. Review of Resident #2's readmission/admission assessment dated [DATE] at 5:03 A.M. revealed the readmission/admission assessment was started and mostly incomplete. The gastrointestinal system section had nothing completed, including information on the residents gastric tube as of 10/16/25. Review of Resident #2's medical record including physician orders, progress notes, Medication Administration Record (MAR), and Treatment Administration Record (TAR) for 10/12/25 through 10/14/25 revealed no evidence for care of the feeding tube site, including monitoring of the site, and drainage: quantity, odor, and appearance. Observation and interview on 10/14/25 at 10:45 A.M. of Resident #2's J-tube on her left side revealed what looked like an ostomy bag with tube feeding coming out of site in bag which was dark brown drainage with what appeared to be granules. Resident #2 reported the peg site was from the hospital that way. Review of the physician orders for 10/15/25 revealed an order was initiated three days after readmission to change jejunostomy tube (J-tube) bag/pouch and set up as needed (PRN), every hour PRN and change J-tube ostomy bag and set up every 3 days. J-tube was a small tube inserted into the jejunum, the second part of the small intestine to provide nutrition when a person cannot eat by mouth. Review of the MARS and TARS for 10/15/25 revealed orders three days after admission to monitor J-Tube site and peri skin every shift. Special instructions to monitor for redness, tenderness, itching, burning, and/or swelling. Report changes to provider and document in a note. Interview on 10/15/25 at 6:36 A.M. with Director of Nursing (DON) confirmed there were no orders for Resident #2 for dressing changes for her J-tube site until 10/15/25. Interview on 10/15/25 at 12:10 P.M. via phone with Physician #301 confirmed Resident 2 should have routine care for the J-tube site. Interview on 10/16/25 at 8:16 A.M. with Licensed Practical Nurse (LPN) #303 confirmed all residents with feeding tubes, to include J-tube should have orders for the care. LPN #303 confirmed after reviewing Resident #2's orders, to include discontinued orders she did not have any orders for the care of her J-tube site on her readmission to facility on 10/12/25, 10/13/25 and 10/14/25. LPN #303 reported orders for the J-tube site were put in on 10/15/25. Interview on 10/16/25 at 9:09 A.M. with Assistant Director of Nursing (ADON) #282 confirmed Resident #2 did not have any orders on her readmission for 10/12/25, 10/13/25, and 10/14/25 for her J-tube site care. ADON #282 confirmed an order for Resident #2's J-tube site care was put in on 10/15/25 and she provided the care on that day. Interview on 10/16/25 at 3:22 P.M. with DON confirmed the readmission assessment for Resident #2 was not initiated until 10/13/25 at 5:03 A.M. DON confirmed the reassessment initiated on 10/13/25 at 5:23 A.M. by LPN #232 was mostly incomplete and the section for gastrointestinal system had nothing documented, including nothing for the J-tube site. Interview on 10/16/25 at 3:28 P.M. with LPN #227 confirmed the admission/readmission is to be initiated promptly by the admitting nurse and</p>		