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	01/08/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, photograph review, and facility policy, the facility failed to ensure medications were stored, prepared, and administrated properly. This had the potential to affect all 47 residents residing on the 100 and 200 hall in the facility. Findings include:Review of the two photographs revealed the first photo dated 11/03/25, at 8:50 P.M. had fourteen (14) medication cups with pills in them and stacked on top of each other unlabeled, and the second photo dated 10/09/25 at 8:12 P.M. had nine (9) empty medication cups, unlabeled on the medication cart. Interview on 12/22/25 at 7:57 A.M. with Resident #22 revealed Licensed Practical Nurse (LPN) #215 is preparing medications on night shift ahead of time without labeling them and stacking them. Interview on 12/24/25 at 8:48 A.M. with Resident #23 revealed a nurse on night shift is preparing medications on ahead of time without labeling them and stacking them. Interview on 12/30/25 at 8:12 A.M. with Confidential Individual #400 confirmed the first photo with the fourteen (14) medication cups with pills in them and stacked on top of others unlabeled are from 11/03/25 at 8:50 P.M. for LPN #215 200 hall medication pass and the second photo of the nine (9) empty medication cups, unlabeled on the medication cart are from 10/09/25 at 8:12 P.M. with for LPN #215's 100 hall medication pass. On 12/24/25 at 10:39 A.M. surveyor showed the two photos to Administrator and DON. DON confirmed the first photo showed 14 medication cups with pills in them, stacked and not labeled and the second photo with nine medication cups, empty and lined up not labeled. Interview on 12/31/25 at 10:06 A.M. with Pharmacist #314 revealed medications are not to be prefilled with pills ahead of time, stacked, and unlabeled. Pharmacist #314 reported medications are to be administered one at a time. Review of facility General Dose Preparation and Medication Administration Policy, revised 11/15/24, revealed only prepare medications for one resident at a time. This deficiency represents non-compliance investigated under Complaint Number 2664936.

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

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	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallmadge Health & Rehab Center	619 Northwest Avenue Tallmadge, OH 44278

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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 0835 Level of Harm - Potential for minimal harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview, record review, and Employee Handbook review, the facility failed to ensure staff were awake at all times to effectively meet the needs of all residents. This had the potential to affect all 81 residents in the facility. Findings include:1. Review of employee personnel file for Dietary Aide (DA) #293 revealed a Disciplinary Action Form dated 12/19/25 for termination for sleeping on the job in the main lobby. Attached to the form was a statement dated 12/19/25 signed by Human Resource (HR) #230 and Administrator. HR #230 found DT #293 sleeping in the lobby and got the Administrator to witness. HR #230 woke DT #293 up and he apologized stating he did not fully intend to fall asleep but had not slept well the night before. Interview on 12/22/25 at 7:57 A.M. with Resident #22 revealed staff sleep on night shift.Interview on 12/22/25 at 1:49 P.M. with Director of Nursing (DON) confirmed DA #293 was found sleeping and was terminated.Interview on 12/24/25 at 8:48 A.M. with Resident #23 revealed staff sleep on night shift.Interview on 12/30/25 at 8:00 A.M. with Confidential Individual #400 revealed they had witnessed staff sleeping on night shift.Interview on 12/30/25 at 12:56 P.M. with Human Resource (HR) #323 confirmed Dietary aide # 277 was found asleep in the lobby. HR #323 reported she called out Administrator to witness and he was suspended on 12/19/25 pending investigation. HR #323 reported he was terminated on 12/24/25 for sleeping on the job.Interview on 01/06/26 at 11:29 A.M. with Administrator confirmed DA #293 was found sleeping on the job and terminated.2. Review of employee personnel file for Certified Nursing Assistant (CNA) # 277 revealed a Disciplinary Action Form dated 12/30/25 for termination for sleeping on the hallway. Interview on 12/22/25 at 7:57 A.M. with Resident #22 revealed staff sleeping on night shift.Interview on 12/30/25 at 8:00 A.M. with Confidential Individual #400 revealed she had witnessed staff sleeping on night shift.Interview on 12/30/25 at 9:50 A.M. via phone with Registered Nurse (RN), Midnight Supervisor # 212 confirmed (CNA) #277 was found asleep on 12/30/25 at 1:32 A.M.Interview on 12/30/25 at 1:43 P.M. with DON confirmed CNA #277 was found sleeping, suspended and would be terminated.Review of Employee Handbook, dated 01/01/24 revealed on pages 36 and 37, for critical offenses, acts considered serious in nature and will result in immediate discharge to include #17, sleeping on the Community's premises during scheduled working hours. This deficiency represents non-compliance investigated under Complaint Number 2664936.