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	03/19/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to maintain accurate and timely medication records of controlled substances and other medications according to acceptable standards of practice. This affected three residents (#1, #17 and #20) of eight residents reviewed for medication administration. The facility census was 86.Findings include:1. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including arthritis, shoulder pain, and need for assistance with personal care.Review of the care plan dated 09/18/25 revealed Resident #20 had chronic pain related to arthritis with a goal of pain reduction. Interventions included administering medications as needed, monitoring complaints of pain, and record alleviating factors. Review of the physician orders revealed an order dated 06/05/25 for tramadol tablet (an opioid pain reliever) 50 milligrams (mg) as needed (prn) for moderate to severe pain every eight hours.Review of the Electronic Medication Administration Record (EMAR) dated 01/01/26 to 01/31/26 revealed documentation of tramadol 50 mg prn on the following days and times: 01/02/26 at 9:31 A.M.; 01/03/26 at 1:10 P.M.; 01/06/26 at 8:16 A.M.; 01/08/26 at 9:08 A.M.; 01/09/26 at 9:42 A.M.; 01/13/26 at 8:48 A.M.; 01/15/26 at 12:01 P.M.; 01/16/26 at 3:40 P.M.; 01/17/26 at 4:30 P.M.; 01/21/26 at 4:04 P.M.; 01/22/26 at 7:10 P.M.; 01/25/26 at 9:39 A.M.; and 01/30/26 at 6:41 P.M.Review of the facility narcotic log dated 01/04/26 to 02/18/26 revealed documentation of tramadol 50 mg prn on 01/09/26 at 10:00 P.M., 01/12/26 at 9:10 A.M., 01/18/26 at 10:00 P.M., 01/21/26 at 9:00 P.M., and 01/23/26 at 9:00 P.M. that were not documented as administered on the EMAR.An interview on 03/19/26 at 3:44 P.M. with the Director of Nursing (DON) verified the documentation findings for Resident #20 and verified when controlled substances are administered documentation should be on the EMAR and the narcotic log. 2.Review of the medical record for Resident #17 revealed an admission date of 03/09/26 with diagnoses including peripheral vascular disease, partial amputation of the right food, stroke, liver disease, and chronic kidney disease. Review of the physician orders for March 2026 for Resident #17 revealed an order for amlodipine (a medication to lower blood pressure) 10 mg once a day, apixaban (an anticoagulant) 2.5 mg once a day, metoprolol (a medication to lower blood pressure) 25 mg twice a day, and pantoprazole (a stomach acid reducer) 40 mg once a day. An observation of medication administration on 03/19/26 at 8:29 A.M. with Licensed Practical Nurse (LPN) #205 for Resident #17 revealed amlodipine 10 mg once a day, apixaban 2.5 mg once a day, metoprolol 25 mg twice a day, and pantoprazole 40 mg once a day were administered to Resident #17. LPN #205 did not sign the medications as given in the EMAR at the time of the observation.An observation on 03/19/26 at 10:38 A.M. of the EMAR for Resident #17 revealed the observed morning medications were still not documented as given.An observation on 03/19/26 at 10:44 A.M. revealed LPN #205 was seated at the nurse's station talking to coworkers and not actively charting at the computer. An interview on 03/19/26 at 10:44 A.M. with LPN #205 verified the morning medications amlodipine, apixaban, metoprolol and pantoprazole observed as administered to Resident #17 at 8:29 A.M. were still not documented as administered on the EMAR. 3.Review of the medical record for Resident #1 revealed (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an admission date of 05/31/22 with diagnoses including leukemia, high blood pressure, dementia with anxiety, major depressive disorder, and Alzheimer's disease.Review of the physician orders for Resident #1 revealed an order dated 06/05/25 for oxycodone (narcotic pain medication) 5 mg twice a day for moderate to severe pain and an order dated 06/05/25 for oxycodone 5 mg every twenty-four hours as needed for moderate to severe pain. Review of the care plan revised 03/13/26 for Resident #1 revealed Resident #1 had pain related to leukemia with a goal for pain reduction. Interventions to include administering medications, monitoring pain, and record alleviating factors. Review of the EMAR for Resident #1 from 01/01/26 to 01/31/26 revealed the absence of documentation for prn administration for oxycodone 5 mg. Review of the paper narcotic log from 01/04/26 to 01/18/26 revealed oxycodone 5 mg was signed out as administered on 01/18/26 at 12:45 P.M., which was not in the scheduled oxycodone A.M. medication pass of 7:00 A.M. to 11:00 A.M. or the P.M. medication pass of 7:00 P.M. to 11:00 P.M. An interview on 03/19/26 at 3:44 P.M. with the DON verified the documentation findings for Resident #1 and verified when controlled substances are administered documentation should be on the EMAR and the narcotic log. Review of the facility policy titled General Dose Preparation and Medication Administration, dated 11/15/24, revealed staff would document the administration of controlled substances in accordance with applicable law, document when medications are given, and document prn medications on appropriate forms.This deficiency represents non-compliance investigated under Complaint Number 2721104.