STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366497	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tamarack Ridge Health and Rehabilitation	5113 State Route 43 Kent, OH 44240

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure Resident #23's skin care was completed as ordered by the physician. This affected one resident (Resident #23) of three residents reviewed for care and services. The facility census was 95.Findings include: Review of the medical record for Resident #23 revealed an admission date of 07/20/23. Diagnoses included paralysis affecting the left non-dominant side, bipolar disorder, depression, muscle weakness, insomnia and respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. He required supervision for eating, partial assistance for oral hygiene, substantial assistance for personal hygiene and was dependent on staff for toileting and showering. He had no noted skin issues.Review of the care plan dated 10/10/25 revealed Resident #23 had an alteration in skin integrity as evidenced by a rash to his left inner thigh/groin area. Interventions included assessing the area for size, color and drainage as needed, providing treatment per physician's orders and assessing for pain.Review of the physician's orders for December 2025 revealed in order to cleanse Resident #23's left inner thigh/groin area with soap and water, pat dry and apply house stock powder (miconazole), an antifungal powder, to the area every shift for a rash. The order began on 06/29/25.Review of the treatment administration record (TAR) for December 2025 revealed the ordered treatment of miconazole powder to Resident #23's left inner thigh/groin area was not signed off as completed per physician's orders on day shift on 12/09/25, 12/11/25, 12/13/25, 12/14/25, 12/18/25, and 12/20/25. Interview and observation on 12/22/25 at 8:08 A.M. with Resident #23 revealed he received a powder to his upper left thigh because it was itchy at times. He revealed some staff were better than others at making sure he received it every day. Observation at the time of the interview revealed a large, red area approximately three inches long by two inches wide on Resident #23's left thigh.Interview on 12/22/25 at 10:09 A.M. with Registered Nurse (RN) #202 revealed she was aware Resident #23 had some issues with skin integrity related to his groin and legs. She revealed the facility was responsible for applying treatments as ordered, since Resident #23 was unable to do so himself. Interview on 12/23/25 at 9:58 A.M. with the Director of Nursing (DON) confirmed she could provide no other evidence the skin treatment ordered for Resident #23 had been completed as ordered.Review of the facility policy titled Skin Assessment, dated 03/15/24, revealed the facility would ensure necessary treatment and services were provided for the completion and documentation of skin integrity. Areas of altered skin integrity would be treated according to medical direction and would be followed conscientiously.This deficiency represents noncompliance investigated under Complaint Number 2649255.

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
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 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 record review, observation, interview, and review of the facility policy, the facility failed to ensure Resident #96's physician orders were followed and care planned interventions were implemented to administer Resident #96's pain medication timely. This affected one resident (Resident #96) out of three residents reviewed for pain management. The facility census was 95.Findings include:Review of Resident #96's medical record revealed an admission date of 12/22/25 with diagnoses including type two diabetes mellitus with diabetic neuropathy, chronic pain syndrome and restless leg syndrome.Review of Resident #96's admission Assessment and Baseline Care Plan dated 12/22/25 included Resident #96 was a new admission and was alert and oriented. Resident #96 used an electric wheelchair and was non-ambulatory. Resident #96 required assistance with physical function, and set-up, supervision with bathing, grooming, and toileting. Review of Resident #96's Pain assessment dated [DATE] included in the last five days Resident #96 was on a scheduled pain medication regimen. Resident #96 received as needed pain medication. Non-medication interventions for pain used were rest and repositioning. Resident #96 had chronic, dull, throbbing bilateral lower extremity pain. Over the last five days Resident #96 frequently experienced pain, pain frequently made it hard for him to sleep at night, and he frequently limited his participation in rehabilitation therapy sessions due to pain. Resident #96 frequently limited his day-to-day activities because of pain. Resident #96 stated rest, mood and emotions were affected by pain. Resident #96's worst pain over the past five days was rated at an eight out of a 10, zero being no pain and 10 being the worst pain. Review of Resident #96's physician orders dated 12/22/25 at 1:11 P.M. revealed pregabalin oral capsule 100 milligrams (mg) (medication to treat nerve pain), give 100 mg by mouth two times a day for pain.Review of Resident #96's physician orders dated 12/22/25 at 1:11 P.M. revealed hydrocodone-acetaminophen (Norco) oral tablet 5-325 mg (opioid pain medication), give one tablet by mouth every six hours as needed for moderate to severe pain. Attempt and document non-pharmacological interventions prior to medication administration.Review of Resident #96's progress notes dated 12/22/25 at 4:39 P.M. included Resident #96 denied pain at this time and stated he had pain in his back and neck at times and required pain medication for relief. Review of Resident #96's progress notes dated 12/22/25 at 6:57 P.M. revealed a message was sent to the Nurse Practitioner (NP) #210 requesting a prescription for Norco be sent to the pharmacy.Review of Resident #96's progress notes dated 12/22/25 at 9:14 P.M. revealed an authorization to pull request for Norco was sent to the pharmacy. Review of Resident #96's Pain Level Summary dated 12/23/25 at 2:23 A.M. revealed Resident #96 had a pain level rated a three out of 10.Review of Resident #96's progress notes dated 12/23/25 at 2:24 A.M. included acetaminophen tablet (Tylenol) 325 mg (analgesic), give two tablets by mouth every four hours as needed for pain was given.Review of Resident #96's progress notes dated 12/23/25 at 2:24 A.M. revealed pregabalin oral capsule 100 mg, give 100 mg by mouth two times a day for pain was not available.Review of Resident #96's progress notes dated 12/23/25 at 3:18 A.M. included Biofreeze cool external gel four percent (topical pain relief), apply to bilateral legs topically every eight hours as needed for pain.Review of Resident #96's progress notes dated 12/23/25 at 4:57 A.M. included acetaminophen 325 mg , two tablets follow up pain scale was one and the Tylenol was effective.Review of Resident #96's progress notes dated 12/23/25 at 4:58 A.M. revealed Biofreeze was effective.Observation on 12/23/25 at 8:10 A.M. revealed Registered Nurse (RN) #211 was preparing Resident #96's medications for administration. RN #211 stated Resident #96 was admitted yesterday. Resident #96 was sitting in a wheelchair and stated, what can I do to get my Norco (hydrocodone-acetaminophen oral tablet 5-325 mg), I am in pain. RN #211 stated Resident #96 did not come with a script for Norco, and the night nurse asked the pharmacy to reach out to NP #210 for a prescription. RN #211 stated Resident #96 should have an order to administer Norco every six hours as needed, but they did not have a prescription for it. RN #211 stated Resident #96 had Biofreeze at 3:18 A.M. and she was preparing acetaminophen 325 mg tablets and was going to administer two tablets now. RN #211 indicated after 5:00 P.M. the on-call NP or Physician had to be called if anything was needed for the residents. Review of Resident #96's Pain Level Summary dated 12/23/25 at 8:17 A.M. revealed Resident #96's pain level was rated a six out of 10.Review of Resident #96's progress notes dated 12/23/25 at 8:17 A.M. included acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for mild pain was given. Observation on 12/23/25 at 9:35 A.M. of RN #211 revealed she was preparing Resident #96's pain medication, Norco 5-325 mg, for administration. Resident #96 was lying on his left side and when he rolled