

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Ridgewood Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3231 Manley Road Maumee, OH 43537	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, review of shower sheets, review of designated smoking times, and review of facility policies, the facility failed to maintain a resident's choice for bathing and smoking when the facility failed to ensure these activities were provided as scheduled. This affected one (#19) of two residents reviewed for activities of daily living and two (#29 and #51) of four residents reviewed for smoking. The facility census was 45. Findings include: 1. Review of Resident #19's medical record revealed an admission date of 11/01/22. Diagnoses included traumatic brain injury, hypertension, and legal blindness. Review of Resident #19's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #19 required set up with showering and bathing. Resident #19 displayed rejection of care behaviors four to six days during the review period. Review of Resident #19's care plan revised 11/20/25 revealed supports and interventions for impaired visual function, potential for falls, and self-care deficit. Self-care deficit supports included providing assistance with bathing/showering. Review of Resident #19's shower sheets for the last 30 days revealed on 12/01/25 Resident #19 shower was documented as not applicable. Observation on 12/01/25 at 9:03 A.M. of Resident #19 found her hair appeared unwashed and uncombed. Interview on 12/01/25 at 9:07 A.M. with Resident #19 found her to be alert and aware. Resident #19 reported her shower days were Mondays and Thursdays on first shift. Resident #19 stated she had not gotten a shower yet and with it being after 9:00 A.M. she most likely would not be getting one that day. Resident #19 stated when she was showered it was earlier in the day. Resident #19 stated she was not able to shower without assistance. Observation on 12/02/25 at 8:08 A.M. of Resident #19 found her to be seated in her chair in her room. Resident #19 was wearing the same clothes as the previous day and her hair continued to be unwashed. Interview on 12/02/25 at 8:09 A.M. with Resident #19 verified she did not get her shower yesterday as scheduled. Resident #19 reported she wanted a shower but no one ever came in to get her for her scheduled shower. Resident #19 stated she would have to wait until Thursday now since that was her scheduled shower day. Resident #19 stated she washed herself up in the sink but did not get the (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower she wanted. Interview on 12/02/25 at 8:32 A.M. with Certified Nurse Aide (CNA) #644 verified with Resident #19 she had not been showered as scheduled yesterday. CNA #644 asked Resident #19 if she would want to have a shower today and Resident #19 stated she would. Resident #19 stated she would put her call light on after she ate to let them know she was ready for her shower. Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, revised April 2025, revealed residents who were unable to carry out activities of daily living independently received services necessary to maintain good grooming and personal hygiene. Review of the undated policy titled, Resident Rights Policy and Procedure, revealed each resident had the right to make choices about aspects of their lift in the facility. 2. Review of the medical record for Resident #51 revealed an admission date of 11/25/25 with diagnoses of acute versus chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and dependence on oxygen. Review of the admission assessment dated [DATE] for Resident #51 revealed the resident was alert and oriented with no confusion. Review of the initial care plan dated 11/25/25 for Resident #51 revealed she was care planned for tobacco use with interventions for smoking cessation if warranted by the resident, education for facility the smoking policy, and orient the resident to smoking times and procedures. Review of a facility document titled, Smoking Contract, dated and signed on 11/25/25 for Resident #51 revealed residents shall be informed of the facility smoking policy to include approved smoking location, and smoking times for their choice of smoking time. Further review of revealed designated smoking times were not listed in the contract; however, the smoking times were listed near the smoking area, and smoking sessions were for 15 minutes in length. Interview on 12/02/25 at 11:35 A.M. with Resident #51 stated there were no cigarettes left out last night (12/01/25) so no one was able to have a smoke break for the 7:00 P.M., 9:00 P.M., or the 6:00 A.M. smoke time. Resident #51 further stated she went to bed last night at 7:30 P.M. because she did not have access to her cigarettes and could not go out to smoke. Interview on 12/02/25 at 11:37 A.M. with Licensed Practical Nurse (LPN) #634 stated she was aware last night (12/01/25) prior to the end of her shift at 7:00 P.M. that the 7:00 P.M. smoke break for the residents could not be taken. LPN #634 further stated the cigarettes were not available for the smokers due to missing lockbox keys where the cigarettes and lighters are kept. LPN #634 further stated she attempted to find the keys and get the cigarettes dispensed and could not find the key or the cigarettes for the residents. LPN #634 stated the 7:00 P.M. smoke break was not given to the smokers. Interview on 12/03/25 at 10:51 A.M. with Resident #29, who was a smoker, stated he was not able to smoke for the 7:00 P.M. and 9:00 P.M. on 12/01/25 smoke break due to no access to smoking supplies. Resident #29 stated the resident's smoking materials were locked and no one was able to get them. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/25 at 11:50 A.M. with Activities Director (AD) #668 stated the activities department was responsible for smoking during the normal business hours and once the 4:00 P.M. smoking time commenced, the activity staff will stock the lockbox with enough cigarettes for each resident to smoke at 7:00 P.M., 9:00 P.M., and 6:00 A.M. AD #668 stated the CNAs are then responsible to give the smoke break during the off hours. Observation at the time of the interview with AD #668 on 12/02/25 revealed two lock boxes for smoking items, one that was kept in the activity room that contained the cartons or multi-packs of cigarettes for the residents and the second lock box was stored in the secured pantry that when stocked contained only the cigarette usage for use during off hours. AD #668 stated both lock boxes had a key lock and confirmed she was not aware the key was not able to be found until it was mentioned in the interview. Review of the facility posted smoking times revealed smoking times were 6:00 A.M., 10:00 A.M., 1:00 P.M., 4:00 P.M., 7:00 P.M., and 9:00 P.M. Review of the facility policy titled, Resident Smoking Policy and Procedure, dated 2025, revealed it is the facility's responsibility to respect a resident's choice to smoke and is balanced by the potential impact on the resident's well-being.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure resident privacy was maintained during personal care and treatments. This affected two (#35 and #31) of 17 residents observed for privacy. The facility census was 45. Findings include: Review of Resident #35's medical record revealed an admission date of 09/22/25. Diagnoses included type I diabetes; traumatic amputation of one lesser toe, subsequent encounter; obesity; generalized anxiety disorder; major depressive disorder; cannabis use; and pancreatitis. Review of Resident #35's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #35 was cognitively intact. Resident #35 was independent with bed mobility, transfer, and dressing. Resident #35 required set up assistance with bathing and toilet use. Resident #35 displayed no behaviors at the time of the review. Review of Resident #35's care plan revised 10/02/25 revealed supports and interventions for enhanced barrier precautions related to a recent toe amputation, self-care deficit, personal care preferences included it was very important for Resident #35 to have privacy when using the telephone, alteration in comfort related to amputation of the left fifth toe and infected wounds on the left foot, and risk for impaired skin integrity. Review of Resident #31's medical record revealed an admission date of 09/19/25. Diagnoses included anoxic brain damage, abnormalities of gait, major depressive disorder, abuse of other non-psychoactive substances, nicotine dependence, and cognitive communication deficit. Review of Resident #31's MDS assessment dated [DATE] revealed a BIMS score of 11 indicating Resident #31 was moderately cognitively impaired. Resident #31 was independent with the majority of activities of daily living and required setup with bathing and personal hygiene. Resident #31 displayed rejection of care behaviors four to six days during the review period. Review of Resident #31's care plan revised 10/02/25 revealed supports and interventions for risk for falls, tobacco use, potential for psychosocial well-being problem related to being homeless, impaired cognitive function, resistive to care, and risk for development of self-care deficit. Observation on 12/01/25 at 11:52 A.M. of Resident #31 and Resident #35 in their shared room found the privacy curtain was tied in a knot, up against the window, and unable to be pulled between the beds for privacy. Continue observation revealed Resident #35 was having wound vacuum (vac) care provided while Resident #31 was eating his lunch seated on the side of his bed facing Resident #35. Interview on 12/01/25 at 11:54 A.M. with Certified Nurse Aide (CNA) #630 verified the privacy curtain was tied in a knot and was unable to be closed for resident privacy. CNA #630 also verified Resident #35 was receiving wound vac care in the line of sight of Resident #31 while he was eating. Further observations on 12/02/25 at 8:32 A.M., 12/02/25 at 11:08 A.M., 12/03/25 at 9:04 A.M., and 12/03/25 at 1:41 P.M. found the privacy curtain between Resident #31 and Resident #35's beds continued to be tied in a knot and unable to be used. Interview on 12/03/25 at 1:43 P.M. with Resident #31 revealed he had not tied the privacy curtain, he was unable to untie the curtain, and verified the privacy curtain was not able to be used for him or his roommate (Resident #35). Resident #31 reported when he wanted privacy he would go into the bathroom. Review of the undated facility policy titled, Resident Rights, revealed each resident had the right to personal privacy including during accommodations, medical treatments, and personal care.		