STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366479	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberland Ridge Nursing & Rehabilitation	3558 Ridgewood Road Fairlawn, OH 44333

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. (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 0684 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 and interview, the facility failed to ensure wound care was provided for #68's wound. This finding affected one resident (Residents #68) of four residents reviewed for wounds.Findings include:Review of Resident #68's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including paraplegia, chronic respiratory failure, osteomyelitis and major depressive disorder.Review of Resident #68's Skin Integrity Care Plan revealed an intervention dated 12/17/23 to assess pain and provide treatments per the physician's orders.Review of Resident #68's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #68's Pressure Skin Grid dated 10/18/25 revealed a vascular rear left calf wound first identified 10/18/25 which measured 3 cm length by 2 cm width by 0.3 cm depth with small serosanguineous drainage. There was no evidence treatment for the wound was put in place immediately. Review of Resident #68's physician orders revealed an order dated 10/21/25 (three days later) to cleanse the left calf with normal saline, apply xeroform, cover with a dry dressing every night shift on Tuesday, Thursday and Saturday.Review of Resident #68's MARS and TARS from 10/18/25 through 10/20/25 revealed the no wound care to the left calf wound. Review of Resident #68's progress note dated 10/21/25 at 1:40 P.M. revealed the resident's heart rate was 154 upon assessment. The resident received as needed metoprolol blood pressure medication and complained of feeling short of breath after the metoprolol. His heart rate decreased to 88 and the reassessment noted by the nurse practitioner revealed the heart rate increased to 160. The resident was sent to the emergency room.Review of Resident #68's Attending History and Physical (hospital paperwork) dated 10/22/25 revealed the [AGE] year-old male presented with generalized malaise tachycardia occasional chest pain and not feeling well on 10/22/25. The resident was recently evaluated by the urologist and prescribed antibiotics for a suspected urinary tract infection (UTI). He was found to be hypotensive with a blood pressure of 83/58 and takes midodrine chronically. The resident was tachycardic with atrial flutter, evaluated by intensive care and cardiology. A chest x-ray shows concern for pneumonia. The diagnoses list included a left lower extremity wound (no sizing or staging was available).Review of Resident #68's Orthopedic Progress Note (hospital paperwork) dated 10/27/25 revealed the chief complaint was a left posterolateral superficial wound with concomitant cellulitis. The documentation also indicated the resident had an unstageable pressure injury to the right heel (hospital acquired), right calf xerosis cutis (hospital acquired) and unstageable pressure injury to the left calf.Interview on 10/28/25 at 12:45 P.M. with RN WN #902 confirmed Resident #68's wound care from 10/18/25 to 10/20/25 revealed no evidence wound orders were placed in the medical record or wound treatments were completed for the posterior left calf.Review of the Skin Assessment policy revised 03/15/24 revealed it was the intent of the facility to provide necessary care to prevent the development of pressure injuries unless the resident's clinical condition demonstrates that the development was unavoidable. Residents with pressure injuries shall receive necessary treatment and services to promote healing, prevent infection, and prevent new injuries from developing which was consistent with professional standards of practice.This deficiency represents non-compliance investigated under Complaint Number 2649063.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician orders were obtained and wound care provided for Resident #28's pressure ulcer wounds. This finding affected one resident (Residents #28) of four residents reviewed for wounds.Findings include:Review of Resident #28's medical record revealed the resident was admitted on [DATE] with diagnoses including muscle weakness, other abnormalities of gait and mobility and cerebral palsy.Review of Resident #28's Alteration in Skin Integrity Care plans dated 10/10/25 revealed to assess for pain and provide treatments per the physician's order. Review of Resident #28's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.Review of Resident #28's Wound #1 Pressure Skin Grid form dated 10/06/25 revealed the resident had a stage one sacrum pressure wound first identified 10/02/25 (earliest stage of skin damage caused by pressure with intact, non-blanchable erythema and/or pain) which measured 5 centimeters (cm) length by 4 cm width by 0 cm depth. The resident was admitted with the sacrum pressure wound.Review of Resident #28's Wound #2 Pressure Skin Grid form dated 10/06/25 revealed the resident had a right ankle deep tissue injury (DTI) first identified on 10/02/25 which measured 2 cm length by 2.5 cm width by undermined depth (a DTI was a localized area of damage to the skin and underlying soft tissue, caused by intense and/or prolonged pressure, or pressure combined with shear). The resident was admitted with the right ankle pressure wound.Review of Resident #28's Wound #3 Pressure Skin Grid form dated 10/06/25 revealed the resident had a left ankle stage three pressure wound (a full-thickness skin loss involving damage of subcutaneous tissue that may extend into underlying muscle) first identified 10/02/25 which measured 2 cm length by 1 cm width by 0.2 cm depth. The resident was admitted with the left ankle pressure wound.Review of Resident #28's Wound #4 right plantar foot blister first identified on 10/06/25 which measured 2.9 cm length by 1.9 cm width by 0.1 cm depth with moderate serous drainage. The blister was in facility acquired.Review of Resident #28's Wound #5 left planter foot blister first identified on 10/06/25 which measured 3.5 cm length by 3.5 cm width by 0 cm depth. The blister was in facility acquired.Review of Resident #28's medication administration records (MARS) and treatment administration records (TARS) and physician orders from 10/03/25 to 10/27/25 did not reveal evidence of a physician order or wound care to the left ankle on 10/03/25, 10/04/25 and 10/05/25; the DTI to the right ankle on 10/03/25, 10/04/25 or 10/05/25; or the stage one to the sacrum on 10/03/25, 10/04/25 or 10/05/25.Interview on 10/27/25 at 1:58 P.M. with Registered Nurse (RN) Wound Nurse (WN) #902 confirmed wound care orders or treatments were not in place for Resident #28's pressure wounds to the sacrum, the right ankle or the left ankle from 10/03/25 to 10/05/25.Review of the Skin Assessment policy revised 03/15/24 revealed it was the intent of the facility to provide necessary care to prevent the development of pressure injuries unless the resident's clinical condition demonstrates that the development was unavoidable. Residents with pressure injuries shall receive necessary treatment and services to promote healing, prevent infection, and prevent new injuries from developing which was consistent with professional standards of practice.This deficiency represents non-compliance investigated under Complaint Number 2649063.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Resident #12 received podiatry services in a timely manner. This finding affected one (Resident #12) of four resident records reviewed for auxiliary services.Findings include:Review of Resident #12's medical record revealed the resident was initially admitted on [DATE], sent out to the hospital on [DATE], sent to a rehab center on 08/04/25 and readmitted to the facility on [DATE] with diagnoses including muscle weakness, vascular dementia and epilepsy. Review of Resident #12's auxiliary services form dated 10/14/25 revealed a consent for vision, podiatry, dental and audiology. Observation on 10/27/25 at 9:24 A.M. with Certified Nursing Assistants (CNAs) #806 and #850 of Resident #12's activities of daily living (ADLs) including dressing and incontinence care did not reveal concerns. The resident appeared clean, and the fingernails appeared clean. Further observations revealed the resident's right and left great toes were long with thickened, yellow toenails.Interview on 10/27/25 at 9:28 A.M. with CNA #806 confirmed Resident #12 had thickened yellowed toenails on the bilateral great toes. Interview on 10/27/25 at 10:49 A.M. with Social Services Designee (SSD) #883 revealed Resident #12 was a skilled patient who was admitted on [DATE], went out to the hospital on [DATE] for a suspected cerebrovascular accident (CVA), was transferred to another facility for rehab on 08/04/25 and transferred back to the current facility on 09/03/25. She stated she was unaware the resident required dental or podiatry services until a care conference which was completed on 10/24/25.A second interview on 10/27/25 at 1:44 P. M. with SSD #883 confirmed a consent for auxiliary services was not obtained when the resident was admitted on [DATE]. She confirmed a consent for services was obtained on 10/14/25 for Resident #12 to see the dentist, audiologist, podiatrist and optometrist. Interview on 10/27/25 at 2:08 P.M. with Regional Nurse (RN) Regional #904 revealed the facility did not have a specific policy related to podiatry services.Interview on 10/27/25 at 2:24 P.M. with the Administrator confirmed the podiatrist's last visit to the facility was on 09/30/25 and the next visit should be 10/28/25.This deficiency represents non-compliance investigated under Complaint Number 2649063.

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. (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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review, and interview, the facility failed to develop and implement a comprehensive, individualized and effective nutrition/hydration plan to prevent weight loss and dehydration for Resident #12. This affected one resident (#12) of three residents reviewed for significant weight loss. The census was 65. Actual harm occurred on 10/01/25 when Resident #12, who had moderate cognitive impairment, was at moderate risk for malnutrition, required cues and assist with eating, and had a care-planned intervention to monitor and provide hydration as prescribed, was assessed to weigh 189.4 pounds representing a 17.3 pound or 8.3 percent (%) severe weight loss in two weeks. The resident was transferred to the hospital (on 10/01/25) and admitted with a change in mental status secondary to dehydration with a five-day hospital stay requiring intravenous fluids. Prior to the hospitalization, the facility failed to ensure ongoing weight monitoring was completed and failed to implement adequate interventions to address the resident's decrease in meal intakes resulting in the weight loss. Findings include:Review of the medical record for Resident #12 revealed an original admission date of 06/10/25, discharge date of 07/27/25 to the hospital, then readmission date of 09/03/25 from another skilled nursing facility (SNF). Resident #12's diagnoses included dementia, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes, muscle weakness, epilepsy and chronic viral hepatitis C. Resident #12 resided on the secured memory care unit.Review of the weight summary from Resident #12's prior admission of 06/10/25 to 07/27/25 in the weights/vitals tab in the electronic medical record (EMR) revealed the resident weight 211 pounds on 06/10/25, 215 pounds on 06/24/25, 215.5 pounds on 07/01/25 and 215.3 pounds on 07/15/25.Review of an admission Assessment and Baseline Care Plan dated 09/03/25 (with a lock date of 09/18/25) revealed Resident #12 was confused, unaware of safety needs and needed assistance with meals. Resident #12's most recent weight was documented to be 206.5 pounds from 09/17/25. There was no evidence that Resident #12 was edematous upon admission.Review of the physician orders from September 2025 revealed Resident #12 was ordered hydrochlorothiazide (a diuretic medication) oral capsule 12.5 milligrams give one capsule by mouth once time a day for edema. The order began on 09/04/25.Review of the Skilled Nursing Note dated 09/06/25 timed 5:51 A.M. revealed there was no evidence Resident #12 had worsening edema or a change in fluid intake.Review of the Skilled Nursing Note dated 09/06/25 timed 11:12 P.M. revealed there was no evidence Resident #12 had worsening edema or a change in fluid intake.Review of the Skilled Nursing Note dated 09/07/25 timed 8:20 P.M. revealed there was no evidence Resident #12 had worsening edema or a change in fluid intake.Review of the Skilled Nursing Note dated 09/10/25 timed 5:44 P.M. revealed there was no evidence Resident #12 had worsening edema.Review of the encounter note dated 09/10/25 timed 11:09 A.M. for date of service of 09/05/25 authored by Nurse Practitioner (NP) #906 revealed there was no evidence Resident #12 was edematous. Review of an encounter note dated 09/10/25 timed 11:10 A.M. for date of service of 09/09/25 authored by NP #906 revealed there was no evidence Resident #12 was edematous.Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #12 was moderately cognitively impaired, used a walker and a manual wheelchair for mobility, had no natural teeth and required (staff) setup or clean-up assistance with eating. There was not a recorded weight included in the assessment.Review of a Malnutrition Risk assessment dated [DATE] revealed Resident #12 was at moderate risk for malnutrition. Review of the Nutrition assessment dated [DATE] authored by Diet Technician Registered (DTR) #860 revealed Resident #12's most recent weight was 215.3 pounds from 07/15/25. The assessment revealed Resident #12 had fair-good intake majority of meals per nursing aide intake records. The resident fed self meals with cues and assist as needed. Resident #12's estimated calorie, protein, and fluid requirements were not calculated. DTR #860 wrote would assess estimated needs when admission weight available. Goals: weight without unplanned significant changes (5% in 30 days, 10% in 180 days) and intakes of at least 75% most meals provided. There was no evidence Resident #12 had edema/accumulation of fluid. Review of the potential for alteration in nutrition and hydration care plan dated 09/11/25 revealed Resident #12 was at risk for malnutrition with a goal of no signs or symptoms of dehydration/electrolyte imbalance/fluid overload. Interventions included: assistance with meals as needed, monitor for signs and symptoms of dehydration and weights per protocol.Review of the Skilled Nursing Note dated 09/12/25 timed 8:42 P.M. revealed there was no evidence Resident #12 had worsening edema or a change in fluid intake.Review of an