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	01/22/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident and staff interviews, the facility failed to ensure the residents who were dependent on staff for toileting hygiene received timely assistance with incontinence care. This affected two (Residents #13 and #42) of three residents reviewed for incontinence care. The facility census was 62.Findings include:1. Record review for Resident #42 revealed an admission date of 10/03/25. Diagnoses included unspecified fracture of the lower end of the right femur, muscle weakness, and need for assistance with personal care.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was cognitively intact. Resident #42 was frequently incontinent of bowel and bladder and was dependent on staff for toileting hygiene.Review of the care plan dated 11/14/25 revealed Resident #42 had an alteration in elimination, and was completely incontinent of bowel and bladder. Interventions included to provide incontinence care as needed. Interview on 01/20/26 at 3:40 P.M. with Resident #42 revealed at times the staff do not change her when she was incontinent and make her wait to be changed for long periods of time. Resident #42 stated last week she told the certified nursing assistant (CNA) that she needed changed and the CNA told her it was meal time and the resident needed to stop needing assistance during this (meal) time. The resident said she didn't plan to require assistance during meal time but she 'accidentally' had a bowel movement and the CNA made her wait until after meal time. Resident #42 revealed she did not know how long she had to wait, but it felt like a long time and she did not like not like waiting so long before getting changed.Observation and interview on 01/21/26 at 10:00 A.M. revealed Resident #42 was lying in bed. Resident #42 revealed she was wet with urine and no one checked her for incontinence or changed her yet today.Interview on 01/21/25 at 10:03 A.M. with CNA #341 revealed she was Resident #42's primary CNA. CNA #341 revealed the CNAs including herself started their shifts at 6:00 A.M. and worked until 6:00 P.M.; CNA #341 confirmed she did not check Resident #42 yet for incontinence and revealed she would do her first set of rounds after breakfast, then again before lunch for a total of about four times in a 12-hour shift. CNA #341 revealed she was getting ready to do Resident #42 for the first time this shift.Observation on 01/21/25 at 10:05 A.M. of incontinence care for Resident #42 provided by CNAs #341 and #348 revealed Resident #42's brief was saturated with urine, the peri area and buttocks was deep red. Resident #42 yelled, ouch as the CNA cleansed the peri area. Interview on 01/21/26 at 11:02 A.M. with CNA #342 revealed she routinely checked and changed her residents three times in a 12-hour shift.Interview on 01/21/26 at 4:32 P.M. with CNA #348 stated if residents need changed, they were not allowed to change them during meals. CNA #348 revealed no patient care was allowed from the time the meal cart arrived on the floor until the last tray was picked up and returned to the meal cart which was usually approximately an hour. CNA #348 confirmed she recalled Resident #42 asking her to change her soiled brief the previous Sunday she worked. CNA #348 stated she did remember Resident #42 asking her to provide incontinence care on a Sunday and it was during mealtime. CNA (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#348 remembered telling Resident #42 she had to wait until after meal service. CNA #348 revealed she did not recall how long after the meal Resident #48 continued to have to wait to be changed and reiterated, It's the rule, they cannot change briefs during meals because they have to pass trays and feed residents or residents complain of cold food. Interview on 01/21/26 at 4:40 P.M. with Licensed Practical Nurse (LPN) #323 stated they were not allowed to do patient care during meals including changing a resident, that has always been the 'rule'. 2. Record review for Resident #13 revealed an admission date of 09/04/25. Diagnoses included muscle weakness, type two diabetes mellitus, and abnormalities of gait and mobility.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 was always incontinent of bowel and bladder and was dependent on staff for toileting hygiene.Review of the care plan for Resident #13 dated 11/14/25 revealed alteration in elimination, completely incontinent of bowel and bladder. Interventions included to provide incontinence care as needed.Interview on 01/20/26 at 3:54 P.M. with Resident #13 revealed she requested her certified nursing assistant (CNA) #360 an hour ago to be changed and CNA #360 said to her before the CNA brings meal trays around she would change her. Resident #13 revealed she had a bowel movement and needed changed.Interview on 01/20/26 at 5:22 P.M. with Resident #13 revealed the staff still has not changed her. Resident #13 said she cannot be provided incontinence care during meals. Resident #13 was supposed to need incontinence care before the meal started, and her call light was on, and was still waiting. Observation revealed Resident #13's call light was on. Resident #13 revealed she was upset she had to sit all that time in her bowel movement.Interview on 01/20/26 at 5:24 P.M. with Registered Nurse (RN) #330 confirmed she was Resident #13's charge nurse and revealed both her CNAs were feeding other residents and it took a long time for staff to provide care to the residents.Observation and interview on 01/20/26 at 5:32 P.M. revealed CNAs #360 and #335 were walking up the hall. CNA #360 revealed Resident #13 never asked her to change her earlier. CNA #335 revealed she normally worked night shift and on night shift, Resident #13 normally used her call light when she wanted changed and she never refused because she was the one who called for assistance. Resident #13 confirmed she requested CNA #360 to change her earlier. CNA #360 rolled her eyes and said no you didn't and this was the first time the CNA was hearing this. Resident #13 said firmly, No you remember, she asked the CNA and the CNA said she would come back before dinner. CNA #360 rolled her eyes and did not respond verbally. Observation of peri care revealed Resident #13 was saturated. There was stool in the peri area. CNA #360 wiped Resident #13 two times from the buttocks area up through the vaginal area revealing heavy stool with each wipe then turned Resident #13 revealing a large bowel movement. Resident #13 had multiple creases on her buttocks, back and upper thighs due to the wrinkled sheets/pad. The buttocks and thighs were red. CNA #360 confirmed while cleaning Resident #13, she only wiped the front two times and wiped from her bottom up revealing stool with each wipe. Interview on 01/21/26 at 4:42 P.M. with the Director of Nursing (DON) revealed staff were allowed to change residents during meals and residents were to be checked and changed every two hours and as needed. This deficiency represents non-compliance investigated under Complaint Number 2702159.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy, the facility failed to ensure medications were securely stored. This affected nine residents (#12, #22, #25, #31, #33, #34, #40, #51, and #53). This had the potential to affected nine other residents residing on the memory care care who were independently mobile and had cognitive impairments. The facility census was 62. Findings include: 1. Observation on 01/20/26 at 10:12 A.M. revealed a medication cart unlocked parked on the west hall. On top of the medication cart were eight medication cups with medications (pills) in each individual cup. There were letters written on each cup. There were no staff near or monitoring the medications on top of the unlocked medication cart. Observation on 01/20/26 at 10:15 A.M. revealed Licensed Practical Nurse (LPN) #300 approached the medication cart after exiting a resident room (Resident #1's room). LPN #300 confirmed she left the medication cart unlocked with eight medication cups with pills in each of them on top of the medication cart, unsupervised in the hall. LPN #300 stated she normally presets the residents' medications for 11:00 A.M. administration. LPN #300 revealed she wrote names (either first or last) on the outside of each medication cup and she would go down the hall and pass them out. LPN #300 confirmed, as she read the name on each cup, Resident #22 had three pills in a medication cup, Resident #40 had two pills, Resident #31 had one pill, Resident #51 had 11 pills, Resident #12 had one pill, Resident #34 had three pills, Resident #53 had two pills and Resident #25 had three pills. LPN #300 then picked up the medication cup for Resident #22, walked in Resident #22's room taking the medication cart with her and handed Resident #22 the medication cup. Interview on 01/20/26 at 10:20 A.M. with the Director of Nursing (DON) revealed nurses should not preset medications and medications were to be administered at the time they were prepared, one resident at a time.2. Record review for Resident #33 revealed an admission date of 09/10/24. Diagnoses included dementia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 was severely cognitively impaired.Observation and interview on 01/21/26 from 8:58 A.M. to 9:03 A.M. revealed on the memory care unit, Licensed Practical Nurse (LPN) #302 was sitting behind the nursing station. LPN #302 revealed her medication pass was completed. Continued observation revealed Resident #33 was lying in bed in her room (located near the end of the hall) with the bedroom door open in the memory care unit. The bedside table was positioned in front of her. On top of the bedside table was a medication cup with nine medications including capsules and a variety of pill sizes. Resident #33 rambled incoherently when spoken to and was unable to answer simple yes or no questions. There were no staff was near Resident #33 or her room.Interview on 01/21/26 at 9:04 A.M. with LPN #302 confirmed she left Resident #33's nine medications in her room, unsupervised for her to self-administer. LPN #302 stated Resident #33 takes her pills herself, and LPN #302 leaves the medications for the resident and Resident #33 does not like to be supervised when taking medications. Interview on 01/21/26 at 4:56 P.M. with the Director of Nursing (DON) confirmed Resident #33 was severely cognitively impaired and resided on the Memory Care Unit. The DON revealed there were no residents residing in the facility who could self-administer their own medications. The DON said Resident #33 would not be appropriate to self-administer her own medications. The DON revealed the nursing staff were required to wait with the residents until all medications were administered. Review of the facility policy titled Medication Storage dated 07/23/19 revealed medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing personnel, pharmacy personnel or staff members authorized to administer medications. This was an incidental finding discovered during the complaint survey.