

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: 366479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Timberland Ridge Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review, the CASPER Payroll Based Journal Staffing Data Report for the Second Quarter of 2025 (01/01/25 to 03/31/25), staffing schedules, posted staffing information, and staff interview, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 63 residents residing in the facility. Findings include: Review of facility staffing schedules, posted staffing information, and the CASPER Payroll Based Journal Staffing Data Report for the Second Quarter of 2025 (01/01/25 to 03/31/25) revealed there was no evidence of Registered Nurse (RN) coverage eight hours a day on 01/04/25, 03/16/25, 08/02/25, and 08/03/25. Interview on 08/07/25 at 2:45 P.M. with the Administrator verified the facility did not have a the required RN coverage and/or any evidence of eight hours of RN coverage in the facility on 01/04/25, 03/16/25, 08/02/25, and 08/03/25.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366479	If continuation sheet Page 1 of 9

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain a sanitary dumpster area. This had the potential to affect all residents residing in the facility. The facility census was 63. Findings include: Observation on 08/04/25 at 8:53 A.M. with Dietary Manager (DM) #825 revealed significant debris including gloves, cardboard, and empty medication packaging on the ground surrounding dumpsters. Interview on 08/04/25 at the time of observation with DM #825 confirmed findings and indicated the maintenance department was responsible for ensuring the area remained clean.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the required members of the quality assessment and assurance (QAA) committee participated at least quarterly as required. This had the potential to affect all residents residing in the facility. The facility census was 63. Findings include: Review of Infection Preventionist (IP) Training Certificate dated 10/24/24 revealed IP #833 was the facility's IP. Review of the Quality Assurance and Performance Improvement (QAPI) sign in sheets from 10/16/24, 01/22/25, 04/02/25, 06/18/25, and 07/16/25 revealed no evidence of participation by the facility's IP. Review of undated facility QAPI Plan revealed the QAA committee members included the IP. Interview on 08/12/25 at 10:04 A.M. with the Administrator confirmed IP #833 had not been attending QAPI meetings. The Administrator indicated the facility's IP was also the Receptionist. The Administrator indicated IP #833 provided a report to the Director of Nursing (DON) to present at the QAPI meetings. Interview on 08/12/25 at 10:20 A.M. with IP #833 confirmed she had not been attending QAPI meetings. IP #833 indicated she had been in the position since she obtained her IP certificate in October 2024.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. Based on observation, interview, and facility policy review, the facility failed to ensure a safe smoking environment. This had the potential to affect all residents residing in the facility. The facility census was 63. Findings include: Observation of the resident smoking session on 08/06/25 at 9:09 A.M. revealed Resident #36 and Resident #52 were supervised by Business Office Manager (BOM) #868 in the smoking area at thee back of the building across the parking lot. The two residents began to smoke. There were four cigarette butts in the smoking area. At 9:17 A.M., Dialysis Technician (DT) #921 walked out of the building, stood next to the door, lit a cigarette, and began smoking. DT #921 was observed talking on the phone and flicking her cigarette ashes. There was a trash receptacle next to the facility door, however there was no approved cigarette disposal. DT #921 walked across the parking lot out of view (next to the smoking area) and walked back into the building without a cigarette butt. Interview on 08/06/25 at 9:19 A.M. with DT #921 verified she was smoking next to the exit door and stated she put the cigarette butt in her pocket. DT #921 rummaged through her pockets and could not find the cigarette butt. DT #921 then stated she put the cigarette butt in the trash can and continued to talk on the phone. Interview on 08/09/25 at 9:50 A.M. with BOM #868 and the Administrator verified the cigarettes on the ground. The Administrator stated employees are to smoke in the smoking area or in their cars. Review of the policy Resident Smoking revised 10/21/22 revealed smoking is only allowed in areas of the facility that are designated smoking areas. Safety measures for the designated smoking area included but were not limited to provision of ashtrays made of noncombustible material and safe design and be located away from exits and common space utilized by other residents in order to protect non-smoking residents from second-hand smoke.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to develop a person-centered care plan for smoking. This affected one resident (Resident #36) of 26 reviewed for care planning. The facility census was 63. Findings include: Review of the medical record for Resident #36 revealed an admission date of 07/03/25. Diagnoses included syncope, dysphagia, difficulty in walking, hypertension, anxiety, adult failure to thrive and depression. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #36 had impaired cognition and required supervision from staff for activities of daily living. Review of the care plan dated 07/10/25 revealed no evidence of a care plan for smoking. Review of the smoking assessment dated [DATE] revealed the resident did not require staff assistance or any smoking devices while smoking. Observation of smoking on 08/06/25 at 9:09 A.M. revealed Business Office Manager (BOM) #868 lit Resident #36's cigarette. Resident # 36 was independent with holding his cigarette and asked BOM #868 to put the butt in the cigarette disposal. Interview on 08/06/25 at 4:30 P.M. with the Director of Nursing (DON) verified Resident #36 had no care plan for smoking. Review of the facility policy Resident Smoking revised 10/21/22 revealed all residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. All residents are to be supervised while smoking.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of facility Self-Reported Incidents (SRI) and corresponding investigation, and facility policy review, the facility failed to provide timely incontinence care to Resident #9. This affected one resident (#9) out of three residents reviewed for activities of daily living. The facility identified nine residents to be incontinent who resided on the [NAME] unit. The facility census was 63. Findings include: Review of the medical record revealed Resident #9 had an admission date of 09/23/21. Diagnoses included cerebral infraction, a stroke, chronic respiratory failure, gastrostomy, tracheostomy, hemiparesis affecting the right side and heart failure. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #9 was cognitively impaired, non-verbal, and dependent on staff for activities of daily living. The assessment identified the resident was always incontinent of bowel and bladder. Review of a SRI dated 07/14/25 revealed the facility reported an allegation of potential neglect/mistreatment of Resident #9. On 07/14/25 at 4:30 P.M., it was reported to the Assistant Director of Nursing (ADON) that Resident #9 had no Certified Nursing Assistant (CNA) enter his room to check and change him on Saturday [07/12/24]. Review of an undated witness statement authored by Licensed Practical Nurse (LPN) #887 revealed she was assigned Resident #9 and was unaware the resident was not checked on 07/12/25. Resident #9 ' s call light never went off. LPN #887 stated she could not watch the CNAs on the [NAME] hallway. LPN #887 stated she went in Resident #9 ' s room and he never showed any distress and she did not notice anything else. Review of a witness statement authored by CNA #842 dated 07/15/25 revealed she was assigned to the [NAME] hallway, along with CNA #805. The two CNAs discussed the room assignments and agreed CNA #805 would care for Resident #9. CNA #842 stated she did not witness Resident #9's call light on in the room. During the shift, the two CNAs worked together and assisted each other as a team. CNA #842 was unaware of any incident. Review of a witness statement authored by CNA #800 revealed she worked on the night of 07/12/25 and found Resident #9 heavily soiled around 9:30 P.M. CNA #800 changed Resident #9's brief and adjusted his linens, joked with him, and proceeded on his assignment. Review of a witness statement for CNA #805 dated 07/17/25 revealed CNA #805 stated they discussed the assignment with CNA #842 and Resident #9 ' s room was never part of the agreed upon room assignments. CNA #805 stated she never worked the room assignment and denied intentionally not providing care to Resident #9. CNA #805 denied any knowledge of Resident #9 putting on his call light during the shift. CNA #842 would have never not provided care and will ensure better communication. Interview on 08/04/25 at 2:35 P.M. with a family member of Resident #9 revealed there was a camera in Resident #9's room and per camera footage dated 07/12/25, Resident #9 went 17 hours with no incontinence care provided. The family member reported the nurse entered the room three times to administer medications and provide tracheostomy care, but there was no incontinence care provided. Interview on 08/06/25 at 4:30 P.M. Administrator revealed he received an allegation of possible neglect on 07/14/25 from a family member of Resident #9 who stated that Resident #9 did not receive any care. The Administrator initiated a SRI and an investigation was initiated. Throughout his investigation, it was discovered there was a missed communication with room assignments and which CNA would be providing care to Resident #9. The Administrator reported the CNAs involved would not intentionally fail to provide care to Resident #9. The Administrator was not able to identify any staff member who provided incontinence care to Resident #9 on 07/12/25. Interview on 08/08/25 at 9:15 A.M. with CNA #842 stated at the beginning of the shift it was discussed that CNA #805 would provide care to the South [NAME] hallway and four rooms on the [NAME] hall that included Resident #9 room. CNA #842 stated Resident #9's call light never went off. CNA #842 denied providing any incontinence care to Resident #9 during her shift. Interview on 08/07/25 at 9:33 A.M. with LPN #887 revealed the nurse worked the (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[NAME] hallway on 07/12/25. Resident #9 ' s room was located on the [NAME] hall. LPN #887 stated they went into Resident #9 ' s room three times to give medication and provide tracheostomy care. However, LPN #887 did not provide Resident #9 with any incontinence care. LPN #887 stated Resident #9 was asked if he needed anything else, and he blinked twice indicating no. LPN #887 stated it was very hard to monitor the CNAs as the [NAME] hall had a heavy medication pass. Review of the facility policy titled Perineal Care dated 10/02/07 stated the purpose is to provide care to genitalia and rectal area, to prevent broken skin and infection, to provide comfort and cleanliness, and prevent body odors. This deficiency represents noncompliance investigated under Complaint Numbers 2568148, 2566992, 1401766 (OH00165165), and 1401764 (OH00165142).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to maintain infection control procedures during incontinence care and failed to ensure enhanced barrier precautions (EBP) were maintained during medication administration through a gastrostomy tube. This affected one resident (#9) out of five residents reviewed for infection control. The facility census was 63. Findings include: Review of the medical record revealed Resident #9 had an admission date of 09/23/21. Diagnoses included cerebral infraction, a stroke, chronic respiratory failure, gastrostomy, tracheostomy, hemiparesis effecting the right side and heart failure. a. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #9 was cognitively impaired and dependent on staff for activities of daily living. The assessment identified the resident always incontinent of bowel and bladder. Observation of Resident #9's incontinence care on 08/06/25 at 10:47 A.M. revealed Certified Nursing Assistant (CNA) #880 and #851 gathering incontinence supplies, washing hand, and donning gowns and gloves. While providing care, CNA #880 took a new incontinence pad off the tray table and placed it on the bed. The incontinence pad fell off the bed and onto the floor, and CNA #880 picked it off the floor and proceeded to place it underneath Resident #9. Interview with CNA #880 on 08/06/25 at 11:00 A.M. verified she picked the incontinence pad off the floor and placed it under Resident #9. Review of the facility policy titled Perineal Care dated 10/02/07 stated the purpose is to provide care to genitalia and rectal area, to prevent broken skin and infection, to provide comfort and cleanliness, and prevent body odors. b. Review of Resident #9's physician's orders revealed a physician order for enhanced barrier precautions dated 03/12/25 and orders for the following medications to be given via gastrostomy tube (a surgically placed tube through the abdominal wall that provides access to the stomach): Baclofen 5 milligram (mg) tablet, aspirin 81mg capsule, buspirone 5mg tablet, escitalopram 20mg tablet, furosemide 40mg tablet, famotidine 20mg tablet, metoclopramide 5mg tablet, and sucralfate oral suspension 1 gram/10 milliliters. All medications had instructions to administer per gastrostomy tube. Observation of Resident #9 medication administration on 08/07/25 at 7:29 A.M. with Licensed Practical Nurse (LPN) #859 revealed signage in the room noting gowns were to be worn when accessing medical devices such as a gastrostomy tube. LPN #859 was observed administering medications through Resident #9's gastrostomy tube without wearing a gown. Interview on 08/07/25 at 8:04 A.M. with LPN #850 verified a gown was not worn while accessing Resident #9's gastrostomy tube and administering medications. Review of the policy Infection Prevention and Control Program dated 11/28/17 revealed it was the policy of the facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. The RNs and LPNs supervise direct care staff in daily activities to assure appropriate precautions and techniques are observed, assess the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's isolation needs, initiate appropriate precautions, and consult with the Medical Director and/or the resident's attending physician. This deficiency represents noncompliance investigated under Complaint Number 1401762 (OH00164467).		