

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365696	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare at Forest Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Reservoir Road St Clairsville, OH 43950	
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)		
<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and policy review, the facility failed to ensure food was served in form to meet residents' needs. This affected one resident (#2) of three residents reviewed for specialized diets. The facility census was 69. Findings include:Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including dementia and dysphagia. Review of orders revealed Resident #2 had an order dated 09/23/24 for a regular diet and texture would be mechanical soft with pureed meats and thin consistency liquids. Review of a care plan dated 02/17/26 revealed Resident #2 had nutritional problems or potential nutritional problems related to presence of chronic disease, a mechanically altered diet, malnutrition risk, and need for supplements. Goals included being free from complaints of hunger or thirst and accepting food as desired and tolerated. Interventions included but were not limited to monitor/document/report to provider as needed for signs and symptoms of dysphagia including pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appearing concerned at meals; and provide and serve diet as ordered. Review of a minimum data set assessment dated [DATE] revealed Resident #2's cognition was severely impaired, she had no swallowing disorder signs and symptoms, and required maximum assistance for eating. Observation on 04/01/26 at 8:20 A.M. revealed Resident #2 was eating at a table in a common area and being fed by a certified nursing assistant (CNA) #102. Resident #2 had a bowl of oatmeal, scrambled eggs, and a bowl of what appeared to be mechanical soft ham. When asked what Resident #2's diet should be, CNA #102 stated she receives mechanical soft except her meat which is pureed. CNA #102 was asked if the ham appeared pureed or if it appeared chunky and she stated it appeared chunky and moved a chunk with her spoon. Resident #2's tray was sent back to request new meat. Review of a policy titled Pureed and Mechanical Soft Foods Production dated 09/08/21 revealed the pureed diet is for residents who have difficulty swallowing and/or residents who are unable to tolerate the mechanical soft diet. Food items are prepared using a food processor or blender and thickener can be added until the food achieves a pudding or mashed potato consistency. Pureed food should not have any pieces in it, does not require chewing, is not sticky and has no lumps. This deficiency represents non-compliance investigated under Complaint Number 2740471.</p>		

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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