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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366177 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/12/2025 |
| NAME OF PROVIDER OR SUPPLIER Cumberland Pointe Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 68637 Bannock 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) |
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| <p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>(continued on next page)</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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| <p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the facility menus, review of incident logs, resident interviews and staff interviews, the facility failed to ensure Resident #47 #53, and #57 were able to make meal choices which aligned with their preferences. This affected three residents (Resident #47, #53, #57) of five reviewed for residents rights with meal preferences. Findings include: 1. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, shortness of breath, chronic pain, dysphagia, major depressive disorder, anxiety disorder, osteoarthritis, presbyopia, hearing loss, insomnia, and osteoporosis. Review of the endoscopy results dated 01/14/25 revealed no observed deficits and recommended upgrading Resident #53's diet from mechanical soft to regular consistency and thin liquids. Review of the physician's orders revealed Resident #53 had a regular diet with regular texture and thin liquids dated 01/14/25. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #53 had intact cognition, was not on a mechanically altered diet, and the resident had no swallowing disorders. Review of the plan of care dated 03/25/25 revealed Resident #53 had alteration in chewing, swallowing related to dysphagia-oral phase, oropharyngeal phase dysphagia, and tracheal deviation. Interventions included educating the resident and family on chewing and swallowing precautions, encouraging the resident to eat slowly and chew thoroughly, follow up with an Ear, Nose and Throat Specialist, monitor weight loss, dehydration, and aspiration pneumonia, monitor for chewing or swallowing difficulties, place the resident in a sitting or upright position during meals, and speech therapy to evaluate and treat as indicated. Review of the progress notes from 02/12/25 to 08/12/25 revealed no documentation of Resident #53 choking on food. An interview on 08/12/25 at 9:45 A.M. with Resident #53 revealed about a year ago they stopped serving them hot dogs and kielbasa. She stated they were told they were a choking hazard. She stated any food item could be a choking hazard if that were the case. She stated she wanted hot dogs especially during the summer cook outs. She stated she was told she could have someone bring her one in, however she had no way of doing that. She stated she had asked numerous times for a hot dog and was always told no. 2. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease, renal dialysis, diabetes, decreased white blood count, neutropenia, cardiomyopathy, hypertension, and peripheral vascular diseases. Review of the physician's orders revealed Resident #47 had an order for a low concentrated sweet, no added salt, regular texture with thin liquid diet and a 1500 milliliter fluid restriction dated 11/17/23. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #47 had intact cognition and had no swallowing disorders. Review of the progress notes from 02/12/25 to 08/12/25 revealed no documentation of Resident #47 choking on food. An interview on 08/12/25 at 12:50 P.M. with Resident #47 revealed the facility had a lot of stuff he did not eat so he would order hot dogs instead, then he was told he could not have hot dogs anymore. He stated he had been ordering cheeseburgers and grilled chicken from the alternate menu, but it would be nice to have a hot dog occasionally. 3. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, nontraumatic intracerebral hemorrhage, acute kidney disease, heart failure, major depressive disorder, intermittent explosive disorder, polyneuropathy, peripheral vascular disease, insomnia, anorexia, mood disorder, hypertension, benign prostatic hyperplasia, and edema. Review of the physician's orders revealed Resident #57 had an order for a regular diet with regular texture and thin liquids dated 05/20/23. Review of the Quarterly Minimum Data Set assessment revealed Resident #57 had intact cognition and had no swallowing disorders. Review of the progress notes from 02/12/25 to 08/12/25 revealed no documentation of Resident #57 choking on food. Review of the Always Offered Menu revealed there were no hot dogs listed on the menu. Review of the four-week menu rotation revealed no encased-link meat on the menu. Review of the incident log from 02/12/25 to 08/12/25 revealed no incidents of choking in the facility. An interview on 08/12/25 at 10:05 A.M. with Dietary Manager #300 revealed she received an email about a year ago stating they were to stop serving encased-meat links. She stated they were not given a reason except that it was corporate wide. She stated she was able to find no-casing sausage links for breakfast and bratwurst patties, but there was not a substitution for hot dogs. She stated several residents had asked for them at resident council. She stated she had to tell them that the facility could not serve them and they must pick something else as their meal of choice. She stated they had also complained to her about hot dogs not being on the</p> | | |