STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366177	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Pointe Care Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on review of a facility investigation, review of personnel files, medical record review and interview, the facility failed to ensure all residents were treated with dignity and respect. This affected one (Resident #36) of five residents reviewed for dignity. The facility census was 65. Findings include: Review of Resident #36's medical record revealed diagnoses including vascular dementia, depression, and impulse disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was able to make himself understood and was able to understand others. The MDS indicated Resident #36 was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of eight (out of 15 total). On 06/18/24 at 10:05 A.M., during the review of State tested Nursing Assistant (STNA) #546's personnel file with Human Resource (HR) Director #500, disciplinary action indicated STNA #546 was found cursing in a resident room and not being professional to co-workers. The discipline form indicated STNA #546 was expected to act in a professional and respectful manner with residents. On 06/18/24 at 2:56 P.M., the Administrator stated when the disciplinary action for STNA #546 was written up on 05/06/24, it due to additional information obtained in the process of a facility investigation. The Administrator provided a packet of papers indicating concerns with professionalism and care. A typed statement dated 05/08/24 indicated STNA #537 reported about one week prior to the interview she asked STNA #546 to change Resident #36 for her and she overheard STNA #546 stating to Resident #36 she could not believe he would let someone else see his [NAME] besides her. STNA #537 reported Resident #36 laughed. STNA #537 reported she told STNA #546 she could not be making inappropriate comments like that to residents and STNA #546 became defensive and stormed off. STNA #537 stated she reported the incident to the nurses but did not know if there was any follow through regarding the inappropriate comments made by STNA #546. Another typed statement indicated the social worker was present during the interview of STNA #546 in which she admitted she might have cursed in front of residents before. There was no documentation regarding response to the allegation related to Resident #36. A typed statement dated 05/10/24 indicated Resident #36 was interviewed with social services present. Resident #36 verified he had heard the statement alleged about why he would let someone else see his [NAME] and he reported it was STNA #546 who said it. Resident #36 reported he just snickered and laughed it off. Resident #36 reported it did not bother him. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/20/24 at 10:43 A.M., Resident #36 was interviewed and was able to recount the statement made by STNA #546 regarding his private parts. Resident #36 indicated it did not upset him as he used to date STNA #546. On 06/20/24 at 12:15 P.M., STNA #546 was interviewed and stated she worked both day shift and night shift but was usually assigned to Resident #36's unit. STNA #546 stated she could have very possibly used foul language in front of residents and visitors. STNA #546 denied she ever dated Resident #36 but he was inappropriate and handsy with staff. STNA #546 did not directly respond to questions regarding any inappropriate comments she did or did not make to Resident #36 but stated she felt another employee was attempting to get her terminated. The employee she named was not the employee who reported the incident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32801 Based on observations and staff interviews the facility failed to ensure resident rooms on the secure unit were clean, safe, and a homelike environment was maintained. This affected three residents (#47, #53, and #60) of six residents observed on the secure unit during the initial survey process. The census was 65. Findings included: 1. Observation on 06/17/24 at 10:15 A.M. of Resident #60's room revealed the electric outlet cover to the left of the resident's bed was noted to be missing. Observation on 06/24/24 at 4:15 P.M., of Resident #60's room with Housekeeping/Laundry Supervisor #525 revealed the electric outlet cover had been placed over the outlet, however the outlet cover did not cover the entire area cut out of the wall. The Supervisor reported the Life Safety Surveyor had already notified the facility of the concern regarding the missing cover; however, she would let the Administrator know the cover did not fit the entire electrical outlet properly. Interview on 06/25/24 at 7:52 A.M., with the Administrator confirmed the Housekeeping/Laundry Supervisor #525 notified her of the concern regarding the electrical outlet not fitting properly and she had sent staff out to purchase a cover that would fit the area. 2. Observation on 06/17/24 at 2:23 P.M. of Resident #47's room revealed the resident's room was not clean. There was an opened bag of chips on the floor beside her nightstand with crumbs on the floor. There was a roll of toilet paper on the floor. The bathroom smelled of feces and there was feces observed smeared on the floor and used toilet paper in her trash can. There were dirty clothes noted in her sink. Observation on 06/24/24 at 4:15 P.M., of Resident #47's room with Housekeeping/Laundry Supervisor #525 confirmed there was feces smeared all over the resident bathroom floor and on the toilet. The supervisor reported the resident places food on the floor to feed nonexistent animals and she uses the sink to wash out her dirty linens. 3. Observation on 06/17/24 at 2:41 P.M., of Resident #53's room revealed the wall beside the bed was gouged and in need of being repaired. The nightstand had the veneer coating peeling off the front of it. Observation on 06/25/24 at 7:52 A.M., of Resident #53's room with the Administrator confirmed there was an area approximately one foot by one foot area on the wall near the head of the bed that was gouged and in need of repair and the veneer coating on the nightstand was peeling off the front of the nightstand.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of missing item reports, review of dental appointment visit lists, family interview, staff interview, and policy review, the facility failed to ensure a resident and her resident representative's concerns of missing dentures were addressed by the facility. This affected one (Resident #47) of two reviewed for personal property. The facility census was 65. Findings include: Review of Resident #47's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder, intermittent explosive disorder, and major depressive disorder. Review of Resident #47's ancillary consent form revealed the resident's representative consented to have her receive dental services as a resident with Medicaid, while in the facility. The consent form was signed on 10/21/21, around the time of her original admission. Review of Resident #47's consultation reports revealed she was last seen by the dentist on 03/14/23. The dentist completed a comprehensive oral evaluation and indicated she was edentulous. The dentist indicated dentures were not applicable in his visit note and did not address whether she had them or not during that evaluation. Review of Resident #47's re-admission assessment dated [DATE] revealed the resident was assessed upon her return following a hospitalization . She was noted to be confused, disoriented, and agitated/ restless. An assessment of her oral status indicated she was edentulous and had full upper and lower dentures. Review of Resident #47's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and was able to make herself understood and understood others. Her cognition was indicated to be moderately impaired. Her assessment did not indicate whether she had problems with her dentures, as it was only assessed as part of a comprehensive assessment (admission, annual, or significant change assessment). Review of Resident #47's care plans revealed the resident had impaired dentition and was at risk for oral problems (i.e. pain, infection, difficulty chewing/swallowing, poor self image) related to her being edentulous. She was identified on the care plan as having full upper and lower dentures and wore them as she desired. The interventions included the need to clean her dentures daily and to encourage her dentures to be worn for meals as she desired. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/24 at 8:10 A.M., an interview with Resident #47's resident representative revealed the resident was missing her dentures and had been for several months now. He stated he had informed the facility about the missing dentures and they were supposed to have her seen by the dentist. He stated the resident was known to refuse to be seen by the facility's visiting dentist and he wanted them to coordinate the dental visit with him so he could be there to ensure the resident complied with being seen. He felt if he was able to be present, the resident would be more likely to allow the dentist to see her and she could get new dentures. Review of the facility's missing item reports for the past 12 months revealed there was no evidence of Resident #47 being known to have missing dentures. She was not one of the residents that had a missing item report filled out for missing property, despite the resident's representative stating he had reported her dentures missing several months ago. The facility did not maintain a missing item log and only had individual reports for residents reporting missing property. Review of the facility's dental appointment lists for past and future appointments revealed the dentist had visited the facility on 04/19/24 and again on 06/11/24. Two residents had been seen by the dentist on those dates, but did not include Resident #47. There was a future appointment with the dental hygienist scheduled for 07/10/24, but no future appointments were scheduled for the dentist yet. On 06/25/24 at 9:43 A.M., an interview with the facility's Director of Nursing (DON) revealed the facility did not utilize a personal inventory sheet to record the residents' belongings that would show whether or not someone had dentures when they were first admitted or during the course of their stay. She thought Resident #47 had dentures at some point and she had talked with the resident's representative about that. She was not sure if she was confusing that with another resident or not. The facility's medical records employee was the one that coordinated ancillary services, such as dental. On 06/25/24 at 9:44 A.M., an interview with State tested Nursing Assistant (STNA) #569 revealed she was not aware of Resident #47 having had dentures. She was asked to check the residents room for evidence of her having dentures. She searched her room and her bathroom and did not see any evidence of the resident having dentures in her possession. There were no denture cups for the storage of any dentures and she did not see any denture related supplies such as denture adhesive or cleaning tablets. On 06/25/24 at 9:45 A.M., an interview with STNA #557 revealed she was not aware of Resident #47 having dentures either. She had not seen her wear any and had not assisted her in the care of her dentures. She stated, if dentures were reported as missing, she would notify the nurse. On 06/27/24 at 9:48 A.M., an interview with Housekeeping/ Laundry Supervisor #525 revealed Resident #47 did mention to her that she was missing her dentures. She stated they looked around to see if they could find them in the resident's room or in other resident's room, but did not have any luck finding them. She recalled it was a month and a half to two months ago, when the resident reported them missing. She stated she thought she informed the facility's Administrator about it and sent a group text out about the reports of the missing dentures, when they could not be found. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/24 at 10:44 A.M., an interview with Social Service Director (SSD) #515 revealed she was not aware of Resident #47 having any reports of missing dentures. She thought the son may have been looking at getting her new ones, at one point, but she would need to double check to make sure that was accurate. The medical records employee coordinated ancillary service appointments and the facility's receptionist handled missing personal items. She confirmed Resident #47 had dentures in the past and was under Medicaid (MCD). On 06/25/24 at 10:50 A.M., an interview with Medical Records Employee #512 revealed she was the staff member that was responsible for the coordination of ancillary services to include dental. She reported the dentist was at the facility last in March 2024 and was due back sometime in September 2024. She was not aware of Resident #47 having any missing dentures. She knew they wanted her on the list to be seen, but may have misunderstood why she was needing to be seen. She stated, if she was aware of the resident having had misplaced her dentures, she would have sent an email to the dental company to get them to come in as soon as possible to get impressions made for new dentures. She stated she would go ahead and send an email over to the dental company to have them come in. The dental company would contact MCD to determine when the last time was that the resident had dentures made. If an item such as dentures were reported missing, they should fill out a paper for it. That would be done by the facility's Administrator or their receptionist, who handled missing personal items. She reported she would have been the one to address the need to replace missing dentures, but stated again she must have misunderstood. On 06/25/24 at 11:05 A.M., an interview with the facility's Administrator revealed she did not recall Resident #47 having had reports of missing dentures. She would have been covering for the receptionist at that time, as the receptionist was off work and had only recently come back. Reports of missing dentures would have required a missing item report to be completed and she denied that she completed one. The Administrator was informed the resident's son did say the resident had been missing her dentures for several months now and the housekeeping/laundry supervisor confirmed she had been informed about the missing dentures about a month and a half to two months ago. She was further informed the housekeeping/ laundry supervisor said she reported it to the Administrator and sent out the report of missing dentures over a group text, with no evidence any follow up was completed regarding the resident's and her resident representative's concerns of missing dentures. She was asked to provide the facility's policy on missing items. She denied they had a policy specific to missing personal items and was to follow the instructions on the missing item report. The directions at the top of the missing items policy/ report indicated when there was an allegation of misappropriation of resident property, a complete investigation would be completed and reported to the State Survey Agency. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Grievances dated 11/22/16 revealed the facility recognized that residents had the right to voice grievances to the facility, or other agencies or entities that hear grievances, without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment that has been furnished, the behavior of staff and other residents and any other concern regarding the resident's stay. The facility will make available to all residents information of the right to file grievances orally or in writing; the right to file grievances anonymously; contact information for the Grievance Official; a reasonable time frame for completing the review of the grievance; the right to obtain a written decision regarding the grievance. The Grievance Committee / Grievance Official shall complete an investigation of the resident's grievance. This may include a review of facility processes, programs and policies, as well as interviews with staff, residents and visitors, as indicated, and any other review deemed necessary by the Grievance Committee. The grievance review will be completed in a reasonable time frame consistent with the type of grievance (e.g., a concern regarding resident conduct will be addressed more quickly than a concern that involves activity programming or meals), but in no event will the review exceed thirty (30) days. Upon completion of the review, the Grievance Official will complete a written grievance decision that includes the following: the date the grievance was received; a summary of the statement of the resident's grievance; the steps taken to investigate the grievance; a summary of the pertinent findings or conclusions regarding the resident's concern(s); a statement as to whether the grievance was confirmed or not confirmed; whether any corrective action was or will be taken; if corrective action was or will be taken, a summary of the corrective action. If corrective action will not be taken, then an explanation of why such action is not necessary; the date the written decision was issued. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved, if applicable. A copy of the written grievance decision will be provided to the resident, upon request. The facility will keep evidence of the resolution of all grievances for a period of three (3) years from the date the grievance decision is issued.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 22653 Based on review of the criminal background check log, interview, and policy review, the facility failed to ensure all staff had a completed criminal background check. This had the potential to affect all 65 residents. Findings include: Review of the facility's criminal background check log revealed notations beside entries for Registered Nurse (RN) #521 (hired 07/20/22), Admission Director #526 (hired 04/20/23), and State tested Nursing Assistant (STNA) #547 (hired 04/23/24) indicating fingerprint submissions to the Bureau of Criminal Investigations had been rejected. There was no evidence fingerprints had been re-submitted. On 06/18/24 at 3:55 P.M., Human Resources (HR) Director #500 verified there had been no completed criminal background checks for RN #521, Admission Director (AD) #526, and STNA #547. Once the fingerprints were rejected, there was no evidence the facility attempted to re-submit fingerprints. HR Director #500 verified if results were not received within 30 days, employees were not supposed to continue to work. On 06/18/24 at 4:04 P.M., HR Director #500 stated after speaking with the Administrator, she was going to obtain and re-submit fingerprints for the three employees (RN #521, AD #526 and STNA #547) that day. On 06/20/24 at 6:36 A.M., the Administrator stated results had been received for the criminal background checks for AD #526 and STNA #547 on 06/18/24 and both employees were retained. Review of the updated criminal background log revealed the fingerprints for RN #521 were submitted 05/18/24 but no results were received. RN #521 continued to work. On 06/20/24, RN #521's fingerprints were resubmitted and results received. RN #521's employment was retained. On 06/20/24 at 8:50 A.M., HR #500 verified AD #526 also had resident contact as she greeted residents on admission and sometimes took them to their rooms. AD #526 also met with residents to complete paperwork, as appropriate and would pass ice at times. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy(dated 11/21/16) revealed prior to hiring a new employee the facility would conduct a criminal background check in accordance with state law and the facility's policy. This deficiency represents non-compliance investigated under Complaint Number OH00153674.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure residents and/ or the resident representatives received written notice of the residents transfer to the hospital and the Ombudsman was notified of the residents' transfer to the hospital as required. This affected two (Resident #5 and #68) of two residents reviewed for hospitalization . The facility census was 65. Findings include: 1. Review of Resident #5's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a urinary tract infection (UTI), Extended-spectrum beta-lactamase (enzymes that confer resistance to most beta-lactam antibiotics including penicillins, cephalosporins, and the monobactam aztreonam) resistance, unspecified psychosis, delusional disorder, vascular dementia with behavioral disturbance, and cognitive communication deficit. She had an attorney listed as her guardian under her emergency contact. Review of Resident #5's census list located in the electronic medical record (EMR) revealed she had hospitalization s that occurred on 04/18/24 and again on 05/28/24. She returned from her hospitalization from [DATE] on 05/02/24 and returned from her hospitalization on [DATE] on 05/31/24. Review of Resident #5's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and was able to make herself understood and was able to understand others. Her cognition was indicated to have been severely impaired. She was noted to have hallucinations, delusions, physical behaviors directed at others, and other behaviors not directed at others that occurred. Review of Resident #5's progress notes reveled she was transferred out of the facility on 04/18/24 related to behaviors (restlessness, agitation, verbal aggression towards staff and other residents, ransacking her room, throwing items, and being difficult to redirect). She left the faciity on [DATE] at 11:45 P.M. She was readmitted to the facility on [DATE]. Further review of Resident #5's progress notes revealed she was sent out to the emergency roiagnom on [DATE], following a fall, and was started on an antibiotic (Cipro) for the treatment of a UTI, while at the hospital. She was returned to the facility, after being evaluated in the emergency room . The hospital contacted the facility, after the resident's return, and wanted to her return to the hospital for intravenous (IV) antibiotics. She was identified as having ESBL resistance. She remained in the hospital until her return to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility was asked to provide copies of the resident's transfer notice and evidence of Ombudsman's notification of Resident #5's transfers to the hospital on 04/18/24 and again on 05/28/24. A review of those requested notices revealed they only had a transfer notice for the resident's hospitalization on [DATE]. There was no evidence of a copy of the transfer notice having been provided to the resident's guardian for the resident's hospitalization on [DATE] and the facility did not have a transfer notice at all for the resident's hospital transfer on 05/28/24. There was also no evidence of the Ombudsman having been notified of the resident's two hospital transfers that occurred on 04/18/24 and 05/28/24. On 06/24/24 at 4:20 P.M., an interview with Social Service Director (SSD) revealed she was the staff member responsible for completing the transfer notices when a resident was transferred to the hospital. She was also the one responsible for notifying the Ombudsman when a resident was transferred out of the facility. She denied she had evidence of Resident #5's guardian receiving a copy of the transfer notice that was completed for the resident's transfer on 04/18/24. She further confirmed she did not have any evidence of a transfer notice even being completed for the resident's transfer to the hospital on 05/28/24. She denied she had notified the Ombudsman of either of the resident's hospital transfers and had not done so until 06/24/24, after she had been asked about it. 44808 2. Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses including cellulitis of the right lower limb, non-pressure chronic ulcer of the right lower leg, type two diabetes mellitus, obesity, chronic myelomonocytic leukemia, hypertension, hyperlipidemia, obstructive sleep apnea, chronic kidney disease, and muscle weakness. Resident #68 was discharged to the hospital on 03/27/24. Review of the progress note dated 03/27/24 at 5:25 P.M. revealed Resident #68 was hard to arouse, oxygen saturation level was 87% on oxygen via nasal cannula at five liters per minute, jerking and twitching movements noted, feces noted draining from perineal fistula, blood pressure was elevated at 195 systolic and 89 diastolic, and the physician ordered for Resident #68 to be sent to the emergency room for evaluation. The note indicated Resident #68's wife was notified, but there was no indication of the method of notification. Review of the Transfer Out of Facility Form - V 4, dated 03/27/24, revealed Resident #68's wife was notified of the transfer and the form did not indicate the method of notification. On 06/24/24 at 11:00 A.M., an interview with Social Services Designee #515 stated Resident #68's wife was notified of the transfer via phone call and confirmed nothing was provided in writing regarding the transfer on 03/27/24. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility's policy on Transfer and Discharges revealed the facility's transfer/discharge notice would be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice would include all of the following at the time it is provided: the specific reason and basis for transfer or discharge; the effective date of transfer or discharge; the specific location (such as the name of the new provider or description and/or address, if the location was a residence) to which the resident was to be transferred or discharged ; an explanation of the right to appeal the transfer or discharge to the State; the name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests; information on how to obtain an appeal form; information on obtaining assistance in completing and submitting the appeal hearing request; the name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman; for nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations. Generally, the notice may be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because an immediate transfer or discharge was required by the resident's urgent medical needs. In those exceptional cases, the notice may be provided to the resident, resident's representative if appropriate, and long term care (LTC) Ombudsman as soon as practicable before the transfer or discharge.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Pointe Care Center	68637 Bannock Road St Clairsville, OH 43950

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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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure residents and/ or the resident representatives received a bed hold notice when residents were transferred out to the hospital and was hospitalized as required. This affected two (Resident #5 and #68) of two residents reviewed for hospitalization s. Findings include: 1. Review of Resident #5's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a urinary tract infection (UTI), Extended-spectrum beta-lactamase (enzymes that confer resistance to most beta-lactam antibiotics including penicillins, cephalosporins, and the monobactam aztreonam) resistance, unspecified psychosis, delusional disorder, vascular dementia with behavioral disturbance, and cognitive communication deficit. She had an attorney listed as her guardian under her emergency contact. Review of Resident #5's census list under the electronic medical record (EMR) revealed she had hospitalization s that occurred on 04/18/24 and again on 05/28/24. She returned from her hospitalization from [DATE] on 05/02/24 and returned from her hospitalization on [DATE] on 05/31/24. Review of Resident #5's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had clear speech and was able to make herself understood and was able to understand others. Her cognition was indicated to have been severely impaired. She was noted to have hallucinations, delusions, physical behaviors directed at others, and other behaviors not directed at others that occurred. Review of Resident #5's progress notes reveled she was transferred out of the facility on 04/18/24 related to behaviors (restlessness, agitation, verbal aggression towards staff and other residents, ransacking her room, throwing items, and being difficult to redirect). She left the faciity on [DATE] at 11:45 P.M. She was readmitted to the facility on [DATE]. Further review of Resident #5's progress notes revealed she was sent out to the emergency roiagnom on [DATE], following a fall, and was started on an antibiotic (Cipro) for the treatment of a UTI, while at the hospital. She was returned to the facility, after being evaluated in the emergency room . The hospital contacted the facility, after the resident's return, and wanted to her return to the hospital for intravenous (IV) antibiotics. She was identified as having ESBL resistance. She remained in the hospital until her return to the facility on [DATE]. The facility was asked to provide copies of the resident's bed hold notice for Resident #5's hospitalization s on 04/18/24 and 05/28/24. There was no evidence of the resident's representative being provided a bed hold notice to inform them of how many bed hold days the resident had, if applicable, or to see if they wanted to hold a bed for the resident until her return from her hospitalization s on 04/18/24 and 05/28/24. Findings were reviewed with Social Service Director #515. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	On 06/24/24 at 4:20 P.M., an interview with Social Service Director (SSD) revealed she was the staff member responsible for providing bed hold notices to the residents and/ or their representatives, when a resident was admitted to the hospital. She denied she had provided Resident #5's guardian with a bed hold notice as required for either hospital admission the resident had on 04/18/24 and again on 05/28/24. 44808 2. Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses including cellulitis of the right lower limb, non-pressure chronic ulcer of the right lower leg, type two diabetes mellitus, obesity, chronic myelomonocytic leukemia, hypertension, hyperlipidemia, obstructive sleep apnea, chronic kidney disease, and muscle weakness. Resident #68 was discharged to the hospital on 03/27/24. Review of the progress note dated 03/27/24 at 5:25 P.M. revealed Resident #68 was hard to arouse, oxygen saturation level was 87% on oxygen via nasal cannula at five liters per minute, jerking and twitching movements noted, feces noted draining from perineal fistula, blood pressure was elevated at 195 systolic and 89 diastolic, and the physician ordered for Resident #68 to be sent to the emergency room for evaluation. The note indicated Resident #68's wife was notified, but there was no indication of the method of notification. Review of the Transfer Out of Facility Form - V 4, dated 03/27/24, revealed Resident #68's wife was notified of the transfer and the form did not indicate the method of notification. On 06/24/24 at 11:00 A.M., an interview with Social Services Designee #515 stated the bed hold policy was provided to Resident #68 and his wife at the time of admission, at which time Resident #68's wife indicated she did not wish for the facility to hold a bed for him. She verified neither Resident #68 nor his wife were provided a bed hold policy at the time of transfer on 03/27/24. Review of the facility's Bed Hold Notice/ Policy revealed Medicaid (MCD) recipients were entitled to take leave days of up to 30 days in a calendar year. After 30 days, MCD would not pay to reserve the bed. If the usage of leave (bed hold) days extended beyond 30 days, arrangements for payment to reserve the bed must be made or the resident would be discharged . If usage days of leave would extend beyond 30 days for the year, authorization must be obtained from the resident (if legally competent), his/ her responsible party, or his/ her guardian to arrange payment to reserve the bed beyond 30 days.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 28923 Based on record review, staff interview, and policy review, the facility failed to ensure a resident had a new resident review completed after a newly diagnosed mental illness was added to their diagnoses. This affected one (Resident #5) of one residents reviewed for Preadmission Screening and Resident Review (PASRR) assessments. Findings include: Review of Resident #5's medical record revealed she was admitted to the facility from another nursing facility on 04/12/24. Her diagnoses included unspecified psychosis (05/02/24), delusional disorder (05/02/24), anxiety disorder (04/11/24), and vascular dementia with behavioral disturbance (05/28/24). Review of Resident #5's Pre-admission Screening and Resident Review (PASRR) identification screen dated 05/05/23 (completed at prior nursing facility) revealed the resident was indicated to have the diagnosis of dementia under section (D.) Medical Diagnoses. The only mental illness (MI) diagnoses included under section (E.) Indications of a Serious Mental Illness was a mood disorder. Review of a Preadmission Screening and Resident Review Result Notice dated 05/05/23 revealed Resident #5 did not have any indications of a serious mental illness and/ or a developmental disability at the time that PASRR identification screen had been completed. Further review of another PASRR Identification Screen completed on 07/28/23 (prior to Resident #5's admission) revealed the resident was identified as having had the diagnosis of dementia under section D. and she was indicated to have mood disorder and panic or other severe anxiety disorder under section (E.). No other mental illness diagnoses were included as being a known diagnoses for the resident under section (E.). No PASRR Identification Screens had been completed upon or after Resident #5's admission to the facility. There was no evidence of a new PASRR being completed, after the resident was known to have the diagnosis of a delusional disorder on 05/02/24. On 06/24/24 at 10:10 A.M., an interview with Social Service Director (SSD) #515 revealed she was the facility's SSD at the time Resident #5 was given a new diagnosis of delusional disorder on 05/02/24. She confirmed she did not complete a new PASRR Identification Screen, after the diagnosis of delusional disorder was given. She denied they had any other PASRR Identification Screens that had been completed that were not the ones that had been completed while at the other nursing facility. She further confirmed a new PASRR Identification Screen should have been completed for the resident, after the diagnosis of delusional disorder was given. She stated she would have to submit a new PASRR to include the diagnosis of delusional disorder for the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure residents bowel movements were properly monitored and those residents who went without a bowel movement for greater than three days received appropriate intervention to promote a bowel movement to occur. This affected two (Resident #5 and #20) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #5's medical record revealed she was admitted to the facility on [DATE] with the diagnoses of vascular dementia with behavioral disturbances, unspecified psychosis, delusional disorder, anxiety disorder, cognitive communication deficit, difficulty walking, chronic pain, and constipation (passing less than three stools a week or having a difficult time passing stool). Review of Resident #5's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was able to make herself understood and was able to understand others. Her cognition was severely impaired. She was known to have delusions, hallucinations, physical behaviors directed at others, and other behaviors not directed at others. A substantial to maximum assist was needed with toileting. She was always incontinent of her bowel. Review of Resident #5's care plans revealed she had a care plan in place for an alteration in elimination as she was usually incontinent of her bowel and bladder. The care plan also indicated the resident was known to have constipation. She required assistance with bathroom location at times and rarely made needs known prior to incontinence. The goal was for the resident to have a bowel movement per her usual pattern. Interventions included assisting with the bathroom location as needed, monitor and record bowel movements every shift, and administer medications as ordered. Review of Resident #5's physician's orders revealed the resident had an order to receive Senna Plus (stool softener) 8.6 milligrams (mg)- 50 mg with instructions to give one tablet by mouth (po) one time a day related to constipation. There was not an order for the resident to receive any prn laxatives for constipation. Review of Resident #5's bowel movement report for the past 30 days (05/22/24- 06/20/24) revealed the resident was not noted to have had a bowel movement recorded between 05/22/24 and 06/05/24 (15 days). Findings were verified by Director of Nursing (DON) #514. On 06/20/24 at 2:10 P.M., an interview with State tested Nursing Assistant (STNA) #557 revealed Resident #5 was an extensive assist with toileting. She indicated the resident's continence status just depended on the day. Bowel movements (BM's) were recorded on the computer when they occurred. She denied they wrote any of the resident's bowel movements on paper. She reported the resident was pretty regular when it came to her having bowel movements and she tended to go a lot. She would think it was a documentation error, if she was not documented as having had a BM in 15 days. She reported the resident's normal bowel pattern was for her bowels to move every other day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/24 at 2:13 P.M., an interview with DON #514 revealed she was able to determine Resident #5 was out of the facility at theER on [DATE] and again on 05/25/24. She was then hospitalized between 05/28/24 and 05/31/24, explaining why BM's were not recorded on those days. She was asked to provide any documented evidence of any BM's the resident had between 05/31/24 and 06/05/24 to show they were monitoring the resident's bowel movements and were intervening as needed, if she was without a BM for three or more days. She later returned at 3:15 P.M. and indicated that she was able to determine that the resident had a bowel movement on 05/31/24, as was indicated in the report they received from the hospital. She then stated they had a three day bowel and bladder tracking that showed the resident smeared on 06/02/24. She was not able to find evidence of a bowel movement of substance occurring between 06/01/24 and and 06/04/24 (four days). She acknowledged that was a four day period without documented evidence of the resident having had a substantial BM. She was asked what the facility's policy or protocol was regarding bowel movement tracking and when to intervene with a laxative to promote the resident to have a BM. She denied they had a bowel protocol and did not have any specific timeframe in which they intervened with a prn laxative. She indicated it would depend on how the resident was feeling. On 06/20/24 at 3:22 P.M., an interview with LPN #555 revealed it was on the dashboard in the computer where they received alerts regarding the resident's bowel movements and need for intervention. They received an alert at 48 hours and again at 72 hours. If the resident was without a BM at 72 hours, they would assess the resident and would review the resident's orders to see if they had a prn laxative. If not, they would call the physician to get an order. She confirmed the resident had an order for scheduled Senna Plus, but currently did not have an order to give a laxative as needed for constipation. 2. Review of Resident #20's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia with anxiety and other behavioral disturbances, intermittent explosive disorder, restlessness and agitation, anxiety disorder, and constipation. Review of Resident #20's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues. She was able to make herself understood and was able to understand others. Her cognition was severely impaired and she was not indicated to have displayed any behaviors nor was she known to reject care during the 7 days of the assessment period. Review of Resident #20's care plans revealed she had a care plan in place for an alteration in elimination. The care plan indicated she was usually continent of her bowel and was known to have constipation. She had episodes of incontinence with behaviors. The goal was for the resident to have soft bowel movements per her normal pattern. The interventions included the need to assist her with the location of the bathroom and toileting as needed. They were to monitor and record bowel movements every shift. Review of Resident #20's physician's orders revealed she had an order to receive Docusate Sodium (stool softener also known as Colace) 100 mg po once daily as needed (prn) for constipation. The order had been in place since 03/16/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's BM record for the past 30 days (05/20/24-06/18) revealed she did not have a documented BM occurring between 05/27/24 and 06/02/24 (seven days). She was noted to have had a large BM on 05/26/24 and not further BM's were recorded until a medium sized BM on 06/03/24. Findings were verified by DON #506 and #514. On 06/18/24 at 3:08 P.M., an interview with DON #506 and #514 revealed residents' BM's were documented under the task tab of the EMR. They denied they would have documentation of a BM that occurred on a paper sheet to support Resident #20 had any other BM's that were not already noted under the task tab of the EMR. They could not provide any additional evidence of the resident having a bowel movement during that seven day period. They further confirmed there was no documented evidence to show the nurses had administered the resident a stool softener (Colace) as was ordered daily on an as needed basis for the resident between 05/27/24 and 06/02/24. DON #506 stated she did not feel the resident was likely to have went without a BM for seven days. She felt it was more likely the resident may have taken herself to the bathroom and had a BM, without the staff being aware. She reported she would check the shift report to see if they had any additional documentation of a BM occurring. On 06/18/24 at 4:10 P.M., a follow up interview with DON #506 revealed she had talked to a couple staff members who indicated Resident #20 had a BM on 06/01/24 that was not recorded. She obtained statements from the two employees with one claiming the resident had a large BM on 06/01/24 and the other indicated the resident had a medium sized BM on 06/01/24. She acknowledged even with a BM occurring on 06/01/24, the resident would have been five days without a recorded BM between 05/27/24 and 05/31/24. She confirmed the resident's MAR's for May 2024 did not reflect the resident was given Colace 100 mg po that was ordered on a daily basis as needed for constipation. DON #506 denied the facility had a policy for bowel movement monitoring, nor did they have a bowel protocol they followed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, record review, interview, and consult notes review the facility failed to ensure Resident #4 was provided orthotic devices and/or restorative exercises for decreased range of motion (ROM) to the right lower extremity. This affected one (Resident #4) of two residents reviewed for positioning. The facility census was 65. Findings included: Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including history of falling, heart failure, sequelae of cerebral infarction, hemiplegia and hemiparesis following a cerebral infarction affecting right dominate side, muscle weakness, unsteadiness on feet, history of traumatic brain injury, osteoarthritis, dysphasia, need for assistance with personal care, epilepsy, and lack of coordination. Review of Resident #4's discontinued orders revealed on 08/16/18 an order was written that the resident may use a knee brace with ambulation at his request. The order was discontinued on 11/11/19. Further review of Resident #4's discontinued orders dated 03/06/20 and discontinued 04/28/20 revealed to refer for consult for ankle/foot orthotic (AFO) to the right lower extremity. Review of Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had limited ROM on one side of the lower extremities. Review of Resident #4's ROM assessment dated [DATE] revealed Occupational Therapy (OT) participated in the assessment and the staff and resident believe he (the resident) could do more. The resident had limited ROM on the right lower side and arm. To maintain strength and endurance, the resident was to perform active range of motion of the right upper extremity using the left upper extremity with a three-pound weight for 10 repetitions three times. Staff were to encourage slow controlled movements and verbal cues for proper pace/technique and task segmentation as needed. There was no documented evidence the limited ROM of the right lower side was addressed or a program was implemented. Review of Resident #4's current orders revealed no evidence of orders for restorative, knee braces, or ankle/foot orthotic (AFO). Review of Resident #4's current plan of care revealed no evidence of a comprehensive/individualized plan of care for range of motion or restorative services. Review of Resident #4's activity of daily living (ADL) plan of care dated 07/09/18 and revised on 05/03/24 revealed the resident required assistance with ADLs and may be at risk for developing complications associated with decreased ADL self-performance related to: behaviors, disease process, cognition problems, stroke, hemiplegia of the right side, chronic obstructive pulmonary disease (COPD), aphasia (difficulty speaking), weakness, and noncompliance. Intervention included assisting the resident with ADL's. Restorative nursing to evaluate and treat as needed. The resident was dependent at times with toileting and transfers (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's comprehensive plan of care including discontinued interventions revealed the intervention for an AFO to the right lower extremity was removed on 03/16/23. The intervention removed indicated to ensure the resident had a knee length sock to the AFO to the right lower extremity and to check the skin prior to application and after removing the AFO. Review of a therapy note dated 05/17/24 revealed active and passive range of motion would be completed to bilateral upper extremity in all planes as tolerated with weights to maintain strength. There was no evidence of a program/recommendation for the limited ROM of the lower extremities. Interview on 06/17/24 at 3:57 P.M. with Resident #4, revealed he lost his right leg brace and then reported therapy had taken his other brace (knee)). The resident reported staff were not providing ROM to his lower extremities and he needed exercise. The resident had difficulty communicating/expressing himself due to dysphasia (difficulty speaking). The resident was noted to propel in a wheelchair by using his left foot to propel himself in his room. Interview on 06/20/24 at 8:15 A.M. with Housekeeping/Supervisor #525, revealed the resident had reported his leg brace was missing over the weekend, however they were not missing because therapy had discontinued the brace. The staff member confirmed the resident had braces because she can recall moving the braces when she cleaned his room. Interview on 06/20/24 8:18 A.M., with Therapy Director (TD) #513 revealed the therapy department was newer in the last year and half and had limited access to previous medical records. TD #513 reported she was unaware the resident ever had an ankle-foot orthotic (AFO); however, the resident had seen an AFO in the therapy room and kept telling staff it was his, but it belonged to another resident. TD #513 reported the resident had an over-the-counter knee brace like you would buy at the drug store that was all stretched out and was not providing any support. The therapy department had bought him a new one, but he didn't like it and the knee brace was returned. Therapy did not try any other type of brace, nor could she recall why he didn't like it for sure. Observation on 06/20/24 at 9:30 A.M., with TD #513 revealed she had gone to follow up with Resident #4 regarding his concerns related to the AFO and braces. She was able to find one of the elastic/compression knee braces. Further observation revealed the resident had a second knee brace that was soft and had straps, however it had missing hardware in the bend of the knee. The TD reported she was not able to find the AFO. The resident kept reporting therapy took it (the AFO). TD reported to the resident that she took the compression knee brace they had bought in April because he kept refusing to wear it and she was not aware he had an AFO. The TD reported therapy had screened the resident, had picked him up for services as a result of the screen and referred him to orthotics to be fitted for a new AFO and knee braces. Interview on 06/20/24 at 9:55 A.M., with Restorative Aide (RA) #536 revealed the resident was receiving active range of motion through the restorative program, when he was compliant, to the upper extremity. RA #536 reported the resident used to wear a compression knee brace; however, it was stretched out and therapy had ordered a new knee brace, but it was too small due to the resident's legs being swollen. The resident's weights were changed to two pounds instead of three pounds as originally recommended due to the facility didn't have three-pound weights. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/20/24 at 10:29 A.M., with Registered Nurse (RN) #520 confirmed Resident #4 did not have orders or a comprehensive plan of care for restorative. RN #520 revealed the facility doesn't write orders for restorative and they don't do an individualized plan of care for restorative programs. RN #520 reported staff were to refer to the task section of the medical record to see if residents were on a restorative program and to document participation with restorative programs in the electronic medical record. RN #520 reported she would have to do some investigating regarding the resident's past use of the AFO and knee braces and why he was no longer using them. Review of therapy screening notes dated 06/20/24 revealed the resident had a knee brace, however the lateral hinges had been removed. The resident would benefit from a consult for orthotics to address deficits, as needed, including possible right AFO and knee brace. Review of Resident #4's orthotics consult and order dated 06/20/24 revealed the resident was evaluated and ordered a right AFO to prevent drop foot and bilateral knee orthotics to stabilize his knees while standing and ambulating. Interview on 06/24/24 at 7:53 A.M., 8:05 A.M., and 8:26 A.M., with RN #520 confirmed the resident had an AFO and knee brace plan of care that was discontinued in 2023. The only thing she could determine was the resident had discharged and upon return the AFO and brace were not re-ordered or addressed upon re-admission. RN #520 reported therapy had screened the resident on 06/20/24 (after concern was identified) and picked the resident up for treatment. Therapy had also called an orthotic provider to evaluate the resident, which they had recommended an AFO and braces and were just waiting for insurance authorization.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Pointe Care Center	68637 Bannock Road St Clairsville, OH 43950

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview and policy review, the facility failed to ensure a resident who was at risk for falls had fall prevention interventions implemented as per her plan of care. This affected one (Resident #47) of three residents reviewed for falls. The facility census was 65. Findings include: Review of Resident #47's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder, intermittent explosive disorder, and a history of falls. Review of Resident #47's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any vision or hearing problems. Her speech was clear and she was able to make herself understood and was able to understand others. Her cognition was moderately impaired. Delusions were present and the resident was known to have verbal behaviors directed at others that occurred daily. She was also known to have other behaviors not directed at others and rejection of care that occurred 1-3 days of the assessment period. Review of Resident #47's care plans revealed she had a care plan in place for being at risk for falls related to Alzheimer's Disease, dementia, impaired cognition, use of psychotropic medications, ambulation being unsteady at times, history of episodes of incontinence, history of falls, poor safety awareness, unsteadiness, episodes of resisting accepting help when unsteady, becoming easily agitated and aggressive at times. Interventions included minimize potential risk factors related to falls and encouraging the resident to gripper socks while in bed and to encourage her to wear shoes when out of bed. Review of Resident #47's physician's orders revealed the resident had an order in place to encourage the resident to wear shoes when out of bed. That order had originated on 05/03/23. On 06/17/24 at 2:31 P.M., an observation of Resident #47 noted her to be up walking in the hall to the dining room where she was noted to sit at a table. She was not noted to be wearing any non-skid socks or shoes at the time of the observation. On 06/18/24 09:58 AM, an observation of Resident #47 noted her to be lying in bed with her feet at the head of the bed and her head at about the middle of the bed. She had her eyes closed and was noted to be bare footed without non-skid socks on. On 06/18/24 at 2:15 P.M., an observation of Resident #47 noted the resident to be sitting in the dining area at a table with another resident and a staff nurse. She was noted to be bare footed and was not wearing any shoes or non-skid socks. The bottoms of her feet were dirty. Another resident in the area was noted to comment on her feet being black and asked the resident why she did not go and get a pair of socks on. Staff in the areas were not noted to have intervened and did not attempt to get the resident to put proper footwear on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/18/24 at 2:38 P.M., an observation noted State tested Nursing Assistant (STNA) #557 approach the Resident #47 in the dining room and was overheard asking the resident if she would allow her to put socks on her. The resident had moved from one table to another (while in her bare feet) before the aide had approached her about putting socks on. The resident agreed to have socks put on and thanked the staff member for offering them as she reported her feet had been cold. STNA #557 was then heard asking the nurse what happened with the resident's slippers that she normally wore. On 06/18/24 at 2:54 P.M., an interview with STNA #557 revealed she did not consider Resident #557 to be at risk for falls. She claimed the resident did pretty good. She was not aware of the resident having had any falls while she was working. She could not speak to whether any falls had occurred on the evening shift. She was asked what fall prevention interventions were in place to prevent the resident from falling. She stated they tried to keep slipper socks (non-skid socks) on her. She sometimes refused everything and they had to catch her at the right time. She was asked what prompted her to approach the resident in the dining room and ask her to put non-skid socks on, after the resident had been observed ambulating in the hall and being in the dining room while in her bare feet. She stated the Director of Nursing (DON) had come by and asked where Resident #47's slippers were. It was then that she put the non-skid socks on the resident at that time. She acknowledged the resident was observed out in the dining room and in the hallway ambulating multiple times the past couple of days with no staff intervention to try to get her to have proper footwear on while out of bed or when ambulating in the hall as per the resident's plan of care. She claimed they tried to get her to put on socks yesterday, but the resident refused. She indicated she would report any refusals of care to the nurse, if it occurred. She was not sure what happened to the resident's slippers. It was believed (after talking with the nurse) that the slippers may have been in laundry after the resident had some sort of accident. Review of the facility's Fall Management policy dated 10/17/16 revealed with the understanding of the significance of mobility, movement, and the ingrained nature of walking, it was their intention to promote programs geared to improving mobility, stamina, and reduce the risk of falls through a comprehensive, interdisciplinary process of assessment, care plan development and implementation with ongoing monitoring and review. Each resident would be assessed throughout the course of treatment for different parameters such as cognition, safety awareness, fall history, mobility, medications, or predisposing health conditions that may contribute to fall risk. An interdisciplinary plan of care would be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32801 Based on review of the facility Payroll Based Journal (PBJ) submission data for the first quarter of 2024, review of the facility assessment, and staff and resident interviews, the facility failed to maintain sufficient levels of direct care staff to meet the total care needs of all residents. This affected six residents (#46, #44, #2, #39, #28 and #51) and had the potential to affect all 65 residents residing in the facility. Findings include: Review of the facility PBJ submission data (staffing data submitted to the Centers for Medicare and Medicaid) revealed the facility was identified to have low weekend staffing during the first quarter (October through December of 2023) of 2024. Review of the facility assessment (last updated 01/21/24) revealed the facility provided staffing levels based on resident acuity levels for each side of the facility. These acuity levels help determine the number of direct care and indirect care needed based on the residents' needs instead of raw number or residents. Nurse managers/Interdisciplinary Team (IDT) were responsible for reviewing/coordinating assignments as needed. The on-call manager functioned in this capacity when the IDT was off duty. a. During the onsite investigation, resident interviews revealed the following: Interview on 06/17/24 at 10:05 A.M., with Resident #46 and Resident #46's son revealed staffing concerns. The resident and son reported there were not enough staff on the weekends. The resident reported she must stay in bed until noon because it takes two staff to assist her with transfers and with insufficient staff, she had to stay in bed later than she preferred. Resident #46 stated her preference was to get out of bed early. Interview on 06/17/24 at 10:46 A.M., with Resident #44 revealed staffing concerns. The resident indicated (in general) the facility needed more aides. If the aides were super busy, she stated she had to wait 45 minutes for help. Interview on 06/17/24 at 10:57 A.M., with Resident #2 revealed staffing concerns. The resident indicated there was not adequate staffing on the midnight shift. The resident stated (in general) sometimes he had to wait one and half hours for someone to answer his call light. Interview on 06/17/24 at 11:03 A.M. with Resident #39 revealed concerns with the facility staffing. The resident indicated at times there were not enough staff and it takes 15-20 minutes for assistance. Interview on 06/17/24 at 11:13 A.M., with Resident #28 revealed staffing concerns. The resident stated the facility needed extra help on all shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 06/17/24 at 11:15 A.M., with Resident #51 revealed concerns related to the facility staffing. The resident indicated night shift staff didn't answer call lights timely and he usually had to wait until dayshift arrived before anyone came to answer his call light. b. During the onsite investigation, interviews with staff revealed the following: Interview on 06/17/24 at 11:40 A.M. with State tested Nursing Assistant (STNA) #547 revealed there was not enough staff, and it takes longer than usual to get things done. The STNA reported there were supposed to be three aides on A unit; however, they often worked with only two. A follow-up interview on 06/18/24 at 6:49 A.M., STNA #547 revealed the STNA worked both day and night shift. The STNA reported there were not enough staff on night shift to provide proper supervision. Last night there were four resident falls (two on each unit) that occurred due to a lack of adequate staff to properly supervise the residents. In addition, the STNA indicated there were two male STNAs working last night and there were some residents who don't like males to provide care, so they pull a female staff member from B hall to help, leaving the other male by himself on the other unit. The STNA stated A wing staffing was worse due to the residents requiring more assistance and there were 10-11 showers required to be done on night shift leaving only one staff on the unit. The STNA revealed the facility had a mandating system for call offs, but the facility doesn't follow the system. Interview on 06/18/24 6:55 A.M., with night shift STNA #571 revealed there were not enough staff on night shift. The aide reported A hall needed at least three STNAs (one for each hall) and two on B hall and there was usually only three to four aides on night shift for the entire building. The STNA stated A hall was rough at night. Usually someone from B hall must go over to help A hall at night at night. This STNA also voiced concerns related to an increase in the number of resident falls on the night shift the previous night. On B hall one resident rolled out of bed, and one slipped on toilet paper in the bathroom. The STNA revealed dayshift staffing was no better. The facility was offering $25 an hour to pick up open shifts but stated there weren't enough staff to pick up due to the facility being short staffed and already working 12-hour shifts. Interview on 06/18/24 at 11:39 A.M. with Housekeeper #519 revealed staffing concerns. The housekeeper revealed there were not enough staff to answer call lights timely and sometimes it takes 20-25 minutes for staff to respond to call lights. Interview on 06/20/24 at 6:13 A.M., with Registered Nurse (RN) #541 revealed management was aware of staffing concerns and just keep saying they were trying to get five aides and three nurses at night. The RN indicated increased supervision/staffing could assist in reducing those falls. Interview on 06/20/24 at 6:25 A.M., with STNA #547 and STNA #568 revealed there was not adequate staffing. The STNA staff indicated extra staff were needed on night shift to give resident showers. When one of the STNAs were in the shower it left the other aide to monitor the hall by themselves and answer call lights. Some of the residents required two assistants (for care). And only a few nurses help. The STNAs voiced concerns related to the staffing on 06/17/24 when there were four falls with some of the falls occurring when staff were doing showers and only one staff was trying to monitor A and C hall. In addition, the secured unit had residents with behaviors who needed increased supervision, so it was difficult to monitor the residents at risk of falls, residents with behaviors, and other residents with one aide available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 06/20/24 7:02 A.M. STNA #536 and STNA #537 revealed concerns related to staffing and indicating there was not enough staff. The STNAs revealed staff run all shifts then try to document in a hurry at the end of the shift. Night shift had 8-12 resident showers to do with some of the residents requiring more than 45 minutes for a shower. That left the other aide to monitor A and C hall, respond to call lights. Multiple residents want to go to bed but require two assists. They must wait on the other side to get done in the shower, so residents were not able to be assisted to bed upon request and then they get angry. The STNAs reported management had told them they had been working on getting staff for more than two years. It was rare there were more than two aides per hall on night shift and staff were told there were no shifts to pick up on nights. These STNAs revealed they also felt insufficient staffing had contributed to falls for lack of supervision. On 06/24/24 at 4:05 P.M. interview with the Administrator revealed the facility had been attempting to schedule an additional nurse on night shift from 7:00 P.M. to 11:00 P.M. to assist with medication and treatment administration, however the facility did not have sufficient staff to schedule that position in a consistent manner. The Administrator revealed when nurses reported off for their shift and staff were unavailable to cover, nursing management were expected to cover the shift. On 06/25/24 at 7:22 A.M. an additional interview with the Administrator revealed the facility was trying to hire additional staff by posting positions through online ads and offering sign on bonuses. This deficieny represents non-compliance investigated under Complaint Number OH00153674.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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** 32801 Based on observation, facility worksheet review, interviews and policy review the facility failed to ensure medication was properly secured and accessible only to authorized staff and failed to ensure insulin was dated upon opening and/or discarded after expiration. This affected five residents receiving insulin (Resident #23, #26, #29, #50, #63) but had the potential to affect all residents residing in the facility. The facility census was 65. Findings included: 1. Observation on [DATE] at 8:22 A.M., with Registered Nurse (RN) #563 revealed a ring of keys were hanging on the wall at the nurse's station, which was not a locked or secured area. The RN retrieved the keys off the wall and opened the medication room door and obtained insulin out of the refrigerator for a resident. The RN then hung the keys back on the wall at the nurse's station before she returned to the medication cart. The RN confirmed the keys were kept on the wall due to the A hall nurses had to share a key and there was only one medication storage room in the facility. A second observation of the medication room keys on [DATE] at 8:41 A.M., RN #562 confirmed the keys for the only mediation room in the building were hanging at the nurses' station and accessible to staff, residents, visitors, etc. The RN retrieved the keys from the wall and opened the medication room door for the surveyor. The RN confirmed there was a key on the keychain that also opened the emergency narcotic cabinet, which she demonstrated for the surveyor. 2. Observation on [DATE] at 9:13 A.M., when walking down A front hall with Therapy Director (TD) #513 revealed the medication cart for A front was unlocked and unattended. This observation was confirmed with TD #513 at time of observation and TD went to find the nurse. Licensed Practical Nurse (LPN) #535 confirmed she left the medication cart unattended and unlocked. Review of the medication carts and keys policy dated [DATE] revealed the facility would maintain and control access to medication carts for licensed and approved personnel. Review of the Medication Storage policy and procedure dated [DATE] revealed medications and biologicals are stored safely, securely and properly following manufacture's recommendations or those of the supplier. The medications supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members authorized to administer medications. Medication rooms and carts are locked or attended to by people with authorized access. 3. Observation on [DATE] at 8:07 A.M. of front A medication cart revealed Resident #23's Busuglar pen was , d+[DATE] used and not dated, Resident #63's Humalog was opened and not dated, and Resident #26 Lantus was opened on [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on [DATE] with Registered Nurse (RN) #563 confirmed Resident #23's and #63's insulins were opened and not dated. The RN reported she would discard the insulins and get new ones due to she had no evidence when they were open and according to the pharmacy, insulin expired usually ,d+[DATE] days after being opened. The RN also confirmed Resident #26 Lantus needed discarded due to it was open on [DATE] and it was past the 28 days and was expired. 4. Observation on [DATE] at 8:37 A.M. of medication cart A back revealed Resident #50's Fiasp flextouch insulin pen was dated [DATE] on the outside of the package and [DATE] on the actual pen. Interview on [DATE] at 8:37 A.M., RN #562 confirmed the insulin should have been discarded because she was not sure when it was open since the package and pen had two different dates and it was open greater than 28 days. 5. Observation on [DATE] at 8:46 A.M., of the secure unit medication cart revealed Resident #29's Deglude insulin pen had 200 units remaining and Euthalia Orend Lispro insulin had 120 units remaining were not dated when opened. Interview on [DATE] at 8:46 A.M., with RN #540 confirmed the insulins should have been discarded do she was not able to determine when the insulins were opened. Review of the facilities worksheet undated titled Medication with Shortened Expiration Dates revealed Fiasp, Basaglar, Lantus, Humalog, expired 28 days after opened. Review of the medication administration policy dated [DATE] revealed insulin is a high risk drug and warrants additional precautions for safe and effective administration. Follow the manufacture's instructions for storage and expiration. Ensure that the opened date is documented on the vial or pen. Refer to Policy 6.2 dating and discharging of multidose vials. Check the expiration date prior to administration to ensure it was within the usage date. Expired insulin should be immediately discarded. Vials and pens without an open dated recorded should be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observations, review of personnel records, policy review, review of time punches, and interview, the facility failed to ensure staff were adequately tested for signs of tuberculosis prior to resident contact and failed to maintain infection control protocols during medication administration and incontinence care. This affected Residents #10 and #15 and had the potential to affect all 65 residents. Findings include: 1. On 06/20/24 at 2:00 P.M., State tested Nursing Assistant (STNA) #567 was observed providing incontinence care to Resident #15. After turning Resident #15 over to provide incontinence care to the buttocks, STNA #567 started cleaning from the top of the buttocks toward the vaginal area. After completing the care, multiple surfaces were touched including the bed remote and blankets while wearing the same gloves worn to provide incontinence care to the resident. On 06/20/24 at 2:13 P.M., STNA #567 verified she had not implemented appropriate incontinence care procedures when she cleaned Resident #15 (from the top of the buttocks toward the vagina). Review of the facility's Skin: Incontinence Care Protocol (revised September 2017) revealed no instruction regarding the proper method to cleanse the skin (front to back). The protocol did not address at what point gloves were to be removed and hand hygiene completed after incontinence care was provided. Review of the facility's Hand Hygiene policy (revised 11/28/17) revealed staff was to perform hand hygiene (even if gloves were used) before and after contact with a resident, after contact with body fluids or other objects and surfaces in the resident's environment, and after removing personal protective equipment such as gloves. 2. During review of personnel files on 06/18/24 starting at 10:05 A.M. with Human Resources (HR) #500, it was noted STNA #546 was rehired on 09/13/23. HR #500 verified there was no evidence a mantoux (tuberculosis) skin test was provided upon re-hire. HR #500 stated STNA #546 had worked at the facility between 03/03/22 to 02/04/23 with a two step mantoux completed upon hire in March 2022. Review of the facility's Tuberculosis Testing and Screening- Healthcare Workers policy (revised July 2016) revealed if a previous negative Tuberculosis Skin Test (TST) result was obtained greater than 12 months before new employment a two step baseline TST was to be administered. 3. During review of personnel files on 06/18/24 starting at 10:05 A.M. with Human Resources (HR) #500, it was noted STNA #547's hire date was 04/23/24. After reviewing time punches, HR #500 verified STNA #547 worked with resident contact made on 04/29/24. The first step mantoux was administered 05/02/24 with results read 05/04/24. HR #500 stated STNA #547 had been working at a hospital as a STNA but did not have the hospital mantoux results. On 06/25/24 at 11:10 A.M., Registered Nurse (RN) #573 provided employee post-offer procedure which indicated the initial mantoux test was required prior to resident contact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Tuberculosis Testing and Screening- Healthcare Workers policy (revised July 2016) revealed if a prospective employee had a documented negative TST result 12 months or less before new employment a single TST was to be administered for baseline testing. The most recent TB (tuberculosis) risk assessment dated [DATE] indicated there was no incident of TB in the facility or surrounding community. 4. On 06/18/24 at 7:28 A.M., Registered Nurse (RN) #534 was observed entering Resident #13's room with medications including an insulin syringe. At 7:33 A.M., RN #534 left Resident #13's room with gloves on. After removing the gloves, RN #534 prepared and administered medications for Resident #10. On 06/18/24 at 7:51 A.M. , RN #534 verified she had not performed hand hygiene between residents. Review of the facility's Hand Hygiene policy (revised 11/28/17) revealed staff was to perform hand hygiene (even if gloves were used) before and after contact with a resident, after contact with body fluids or other objects and surfaces in the resident's environment, and after removing personal protective equipment such as gloves. This deficiency represents non-compliance investigated under Complaint Number OH00153674.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview, and policy review the facility failed to ensure residents met criteria of antibiotic treatment. This affected one (Resident #17) of two reviewed for antibiotic stewardship. The facility census was 65. Findings included: Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnosis including stage three kidney disease. Review of Resident #17's five-day Minimum Data Set (MDS) 3.0 Assessment revealed the resident was occasionally incontinent of bladder and frequently incontinent of bowel. Review of Resident #17's progress note dated 06/11/24 revealed the resident was having pain under the left breast that was not relieved with Tylenol. The resident agreed to go to the hospital to be checked out for peace of mind. Review of Resident #17's hospital note dated 06/12/24 revealed the facility sent resident to emergency room for chest/flank pain times for one week. The resident was alert and oriented times four and denies pain and reported he didn't know why he was there. He just had aches and pain from being old. The temperature was 98.6. The resident has chronic kidney disease. His urine showed large leukocytes, moderate bacteria, many white blood cell clumps, and was positive for nitrite and protein. The resident's troponin levels (laboratory test used to assess heart damage) were elevated. Rocephin (antibiotic) intravenous was started. The family requested the troponin level be rechecked to determine if they would like him sent back to the nursing home or admitted . The level remained elevated however the resident was sent back to the nursing home with an order for Keflex (antibiotic) 500 milligrams (mg) four times a day for seven days for a urinary tract infection (UTI). Review of Resident #17's orders and medication administration records (MAR) dated 06/2024 revealed the resident was ordered Keflex 500 mg four time daily for a UTI on 06/12/24. The resident received three doses on the 12 th, four doses on the 13 th, 14 th, 15 th, and 16 th and one dose on the 17 th and then it was discontinued, and new orders were received to start Cipro (antibiotic) 250 mg twice daily for UTI, however it was never administered. Review of Resident #17's progress notes dated 06/12/24 to 06/17/24 revealed the resident was receiving Keflex for a UTI and had no adverse effects and was asymptomatic (for the UTI). Review of Resident #17's progress note dated 06/17/24 revealed the emergency room called to report that Keflex was resistant to the bacteria organism found in the resident's urine specimen and recommended Cipro 250 milligrams twice daily for 10 days. The resident's physician was notified and was agreeable. Review of Resident #17's progress notes dated 06/18/24 revealed the resident's physician was notified the resident did not meet criteria for (treatment of a) UTI. Orders were received to discontinue the antibiotics and repeat a urine culture despite the resident already receiving antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366177	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Pointe Care Center	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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the infection control log dated 06/20/24 revealed the resident didn't meet criteria for treatment of the UTI and had greater than 100,000 colony forming units per milliliter of urine of the bacteria, Enterobacter cloacae. Keflex 500 mg four time a day for seven days was ordered from 06/12 to 06/17/24 and Cipro 250 mg twice a day for 10 days (06/17/24-06/27/24) with pain below the right breast. Review of the McGeer and Loeb's worksheets dated 06/12/24 revealed the resident did not meet criteria for treatment of the UTI. Review of Resident #17's culture results undated revealed no evidence of Keflex (Cephalosporins) sensitivity to the bacteria in the resident's urine. There was a note to avoid 3rd generation Cephalosporins for treatment due to inducible resistance despite demonstrated susceptibility on the initial report. Further review of the urine culture result notes revealed on 06/15/24 new orders from the hospital to discontinue Keflex as bacteria in the urine is resistant to that drug class. Start Cipro 250 mg twice a day for 10 days and Florastor (probiotic) 250 mg daily for 14 days. The hospital attempted to call the resident on 06/15/24 twice and once on 06/17/24. The hospital was able to locate the resident in the skilled nursing facility and gave new orders to the nurse. Interview on 06/20/24 from 2:28 P.M. to 3:16 P.M., with the Infection Preventionist (IP)/Co-Director of Nursing #514 revealed she was off last week, and the Director of Nursing (DON) was covering. The hospital was trying to contact the resident at home regarding the culture results. The IP confirmed the resident did not meet criteria for treatment and the provider was not notified until 06/17/24. The IP reported she just provided the DON with education regarding this matter. Review of the facility policy titled Antibiotic Stewardship dated 11/28/17 revealed the purpose of the policy was to optimize the treatment of infections while reducing events associated with antibiotic use. McGeer and Loeb criteria would be used to determine whether to treat an infection with antibiotics. Antibiotic orders obtained upon admission or readmission to the facility shall be reviewed for appropriateness, as well as those obtained from emergency providers.

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	366177	A. Building B. Wing	06/27/2024

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview, and policy review the facility failed to ensure residents received the pneumococcal vaccine per recommendation. This affected one (#59) of five residents reviewed for immunizations. The facility census was 65. Findings included: Record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including encephalopathy, dementia, hypertension, hyperlipidemia, hypothyroidism, and anxiety. Review of Resident #59's pneumococcal consent form dated 01/10/24 revealed the resident had already received the pneumococcal vaccine, however it was not checked which one was received or the date it was received. Review of Resident #59's immunization tab in the electronic medical record revealed the resident as not eligible for pneumococcal 13 or 20 vaccine. Interview on 06/18/24 at 11:03 A.M., and 2:28 P.M., with Infection Preventionist (IP)/Co-Director of Nursing (DON) #514 revealed she was not sure which vaccine the resident received and would need to call the family to follow up. The resident's family returned her call but were not sure and asked her to call the previous facility she resided at to verify The IP reported she called the Resident Care Facility where the resident previously resided and they only had documented the resident refused. DON #514 called the family back and they were sure she received a vaccine and then asked her to call the pharmacy. The IP called the pharmacy and the pharmacy reported on [DATE], the resident had the PPSV23 and prior to that on 10/17/2017 she had PCV13. The IP called the daughter back and she gave permission to give the Prevnar 20 since it had been more than 5 years since the resident had been vaccinated. The IP ordered the Prevnar, and it should arrive tonight. The IP reported she would provide education to the nursing staff. Review of the facility pneumonia vaccine policy and procedure dated 07/03/23 revealed the pneumonia vaccination would be offered unless it was medically contraindicated, or the resident had already been immunized. Each resident may be evaluated for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. The type of pneumococcal vaccine offered would depend upon the recipient's age and susceptibility to pneumonia, in accordance with the current Centers for Disease Control (CDC) guidelines and recommendations.

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have enough backup water supply for essential areas of the nursing home. 22653 Based on review of documents from the facility's food supplier and interview, the facility failed to ensure provisions were made to have water available in the event of an emergency. This had the potential to affect all 65 residents. Findings include: During the entrance conference on 06/17/24, the Administrator was asked what provisions the facility had made to ensure the availability of water in the case of an emergency. A document from the facility's food service supplier dated 11/01/23 was provided. The agreement indicated in the event that an emergency affected the facility, the food supplier might not be able to provide the facility with the recommended amount of water needed during an emergency situation and recommended the facility ensure they had an alternate vendor set up. On 06/18/24 at 11:59 A.M., the Administrator verified the facility had not made alternate arrangements for the provision of water in the event of an emergency.