

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Cumberland Pointe Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 68637 Bannock Road St Clairsville, OH 43950	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, including review of facility billing/financial information, interview, and review of the Administrator Job Description, the facility failed to be administered in a manner to prevent potential interruption in service or delay in receipt of inspection reports as a result of not following up timely to failed generator testing. This had the potential to affect all 66 residents residing in the facility. Findings include: In an interview on 09/11/2025 at 7:56 A.M. with Maintenance Director (MD) #501 revealed he had been employed by the corporation for three years. During the interview, MD #501 shared the concurrent life safety code survey had identified a concern related to the diesel generator system not being properly maintained following the inspection by the contracted company, Western Branch Diesel because he had not received the report from the company. The MD revealed someone at corporate had not paid the bill, therefore the report was not generated. He thought they had to pay \$500 before it was able to be completed. Additional review revealed the last fuel analysis report for the diesel fuel in the emergency generator by the contractor was dated 08/14/24 and the fuel sample had failed the testing requirements. Further review revealed an interview with the Maintenance Director verified they had not received the results of the testing until they requested them from the generator contractor on the day of the survey, 09/08/25. On 09/11/2025 at 9:45 A.M., a phone interview with a Western Branch Diesel account representative revealed the facility had been delinquent with their account which had caused delays in service of the diesel generator, and the facility was currently waiting on samples which took approximately three or four days to complete. He indicated the facility accounting department and Western Branch accounting department got together this week and brought the account to current with an open line of credit. On 09/11/2025 at 11:15 A.M., an interview with the Administrator revealed he did not directly pay all facility bills. Local bills, including the local grocery, the water bill and whatever other small ones, were paid directly by the facility after he approved them. Other bills, including [NAME] Food Services and [NAME], which included larger volume services, were paid from a global account with corporate services and he never had to approve or see these invoices. During the interview, the Administrator revealed he believed there was a miscommunication with Western Branch Diesel resulting in non-payment of their outstanding bill. He reported Western Branch always used a biller for their account and indicated the biller had changed at some point in the recent past and the new biller had been sending invoices to an incorrect email, resulting in the facility not paying the past due account. Review of an invoice dated 03/13/25 to be paid to Western Branch Diesel revealed a balance due of \$1,522.95. The date of service was 02/21/25 for a sister facility, owned and operated by the same corporation as [NAME] Pointe. Review of a copy of a check dated 07/30/25 revealed the check was made to the order of the Western Branch Diesel, Inc. in the amount of \$1,522.95. There was no evidence the check had been cashed by the company. Review of the contract between the facility and Western Branch Diesel revealed Western Branch Diesel was responsible for routine/annual generator preventative maintenance. Review of the Administrator job description revealed the facility administrator would be responsible for all financial transactions for the facility.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, observation and interviews, the facility failed to ensure dignity was maintained related to urinary catheter drainage bags and mealtime. This affected two residents (Resident #2 and #70) of three residents reviewed for dignity. The facility census was 66. Findings include: 1. Record review for Resident #2 revealed an admission date of 06/12/25 with diagnosis of obstructive uropathy, diabetes mellitus, congestive heart failure, and severe malnutrition. A review of the admission minimum data set assessment dated [DATE] revealed Resident #2 had moderate cognitive impairment and required maximum assistance for hygiene and was totally dependent upon staff for dressing, bed mobility, transfers, and nutrition. Review of the physician's orders revealed an order dated 06/12/25 for an indwelling urinary catheter to closed drainage related to a diagnosis of obstructive uropathy. An observation on 09/08/2025 at 10:27 A.M. revealed Resident #2 was lying in bed with an indwelling catheter. The urinary drainage bag was hanging on the bed frame without a private bag covering the drainage bag, with urine visible in the bag and the drainage bag was visible from the doorway. An interview 09/08/2025 at 11:15 A.M. with Licensed Practical Nurse (LPN) # 563 verified Resident #2's urinary catheter drainage bag did not have a privacy cover on it at the time of observation. 2. A record review of Resident #70 revealed an admission date 10/09/12 with diagnosis of Alzheimer's disease, and need for assistance for personal care. A review of the quarterly minimum data set assessment dated [DATE] revealed that Resident #70 had severe cognitive impairment and required moderate to maximum assistance for eating and was dependent upon staff for performance of all other activities of daily living. An observation on 09/08/2025 at 12:42 P.M. revealed Certified Nursing Assistant (CNA) #556 approached Resident #70 and asked her to eat. CNA #556 stood over Resident #70 and attempted to feed Resident #70 some pears from her lunch tray while standing next to the resident. Resident #70 ate one bite and refused to open her mouth for more food. An interview on 09/08/2025 at 12:50 P.M. with CNA #556 verified they did attempt to feed Resident #70 while standing. CNA #556 verified they were aware staff should be seated while assisting residents with eating.		

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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** Based on medical record review, observations, and interviews the facility failed to ensure orders for restorative therapy were implemented timely. This affected one (Resident #12) of five residents reviewed for positioning. The facility census was 66. Findings include: Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including myocardial infarction, Parkinsonism, diabetes, muscle weakness, need for assistance with personal care, lack of coordination, muscle wasting and atrophy, tremors, difficulty walking, peripheral vascular disease, dementia, and other abnormalities of gait and mobility. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) was 12 (moderate cognition impairment) out of a possible 15 score, the resident had rejected care one to three days and had daily verbal behavior. The resident was dependent for mobility, supervision or touching assistance for eating, and had limited range of motion of both lower extremities. The resident did not receive restorative therapy. The resident had received speech, occupational, and physical therapy from 03/12/25 to 04/10/25. Review of Resident #12's assistance with activities of daily living (ADL) plan of care dated 02/11/20 revealed the resident may require assistance with ADL's and may be at risk for developing complications associated with decreased ADL self-performance related to dementia, dysphagia (difficulty swallowing), stroke, hemiplegia, weakness, psychiatric diagnoses physical limitations, unsteadiness, weakness, and fatigue. Assistance may vary from day to day, situation, and time of day. Resident was able to take a few steps a short distance, will do this when she is agitated/frustrated. The resident resists taking showers, out of bed some days. Experiences normal fluctuations in her mood/behavior/cognition affecting her participation in ADL's, socialization, and staff interactions. The resident's participation levels may vary according to mood/behavior. On 07/15/25 poor participation in restorative program was added to the plan of care. The resident's intervention included restorative nursing to evaluate and treat as needed, to encourage activity during daily care, explain all procedures prior to care, make adjustments to programs as necessary, monitor decline in care and report to clinical staff as needed, therapy to screen and provide treatment as indicated. Review of Resident #12's neurological note dated 07/29/25 revealed the resident was seen for a follow up. Per nursing staff, the resident had been stable and had no seizure activity. Tremors and memory were stable. The plan included continuing medications and may increase Exelon patch at next visit for impaired memory and chronic encephalopathy. For the deconditioning, impaired walking, with abnormal sensory exam the plan was restorative physical therapy for upper extremities three times per week due to the resident having maxed out physical therapy. Review of Resident #12's task revealed no evidence the resident had received restorative therapy from 07/29/25 to 09/11/25. Interview on 09/08/25 at 4:57 P.M., with Resident #12's brother revealed he had concerns with staff not getting his sister out of bed and assisting her with meals. Resident #21's brother reported he had spoke with the facility regarding these concerns, however every time he visited, she had been in bed, and he had to assist her with meals. Interview on 09/11/25 at 3:13 P.M., with Director of Nursing (DON) #512 confirmed Resident #12 was not receiving restorative services per the neurologist orders on 07/29/25. The DON reported the resident had refused restorative services in the past. Interview on 09/11/25 at 3:13 P.M., and 09/15/25 at 11:03 A.M., with Therapy Manager/Physical Therapy Assistant (PTA) #601 confirmed she was not aware the neurologist had made recommendation for restorative on 07/29/25. PTA #601 reported therapy had performed a quarterly therapy screen on 08/11/25, however staff had not reported any changes, or the neurologist had ordered restorative therapy therefore the resident was not picked up for therapy or restorative services. The PTA confirmed during the quarterly screen the therapist does not touch the resident and just performed observations and interviews to determine if (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents need evaluation for services. The PTA reported the resident had a history of refusing restorative, however if she had known the neurologist had ordered restorative service, the facility would have attempted to provide restorative services. The PTA reported therapy had screened the resident on Friday (09/11/25) and speech and occupation therapy had picked up the resident for services. The resident had refused the physical therapy screen on Friday 09/12/25, however the physical therapist was going to try again today, 09/15/25.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on medical record review, review of fall incident report, interview, observation the facility failed to ensure fall interventions were in place per plan of care and failed to ensure in use wheelchairs were maintained without cracks, tears and exposed padding. This affected two residents (Resident #5 and #8) of three residents reviewed for accidents. The facility census was 66. Findings include: 1. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including fracture of rim of left pubis and left acetabulum, repeated falls, cognitive communication deficit, hallucinations, disorientation, weakness, and end stage renal disease. Review of Resident #5's fall report dated 09/10/24 to 09/10/25 revealed the residents had fifteen falls in one year. Review of Resident #5's fall plan of care dated 10/01/24 revealed the resident was at risk for falls due to debilitation, weakness, dementia, impaired cognition, memory impairment, pain, poor decision making, use of psychotropic medication, rare episodes of incontinence, difficulty walking, abnormal gait/mobility, and repeated falls. The fall intervention included on 02/19/25 visual reminder to wear non-skid footwear was added and 04/29/25 motion sensor in room was added. Observation on 09/10/25 at 7:55 A.M. of Resident #5's room with the Maintenance Director (MD) revealed the motion detector was not alarming/sounding and no evidence of a visual reminder to wear non-skid footwear. The surveyor and MD were walking around in the resident room without the motion detector alarming. Observation on 09/10/25 at 8:05 A.M., of Resident #5's room with Registered Nurse (RN) #541 revealed the motion detector was not alarming/sounding and no evidence of a visual reminder to wear non-skid footwear. The RN was walking around the room and removed a dressing from the resident's left leg without the motion detector alarming. Observation on 09/10/25 at 8:20 A.M., of Resident #5's room with Certified Nursing Aide (CNA) #554 revealed the motion detector was not alarming/sounding. The CNA confirmed the motion detector was not functioning properly. The CNA attempted to reset the motion detector several times; however, it continued to not function. Observation on 09/10/25 at 2:33 P.M., of Resident #5's room with Director of Nursing (DON) #512 confirmed there was no visual reminder to wear non-skid footwear per the resident's plan of care. The DON reported that the resident was recently moved to this room and maybe the visual reminder was left in the other room. Observation of the resident's previous room revealed no evidence the visual reminder remained in that room. Interview on 09/10/25 at 8:26 A.M., with RN #541 confirmed during observation on 09/10/25 at 8:05 A.M., the motion detector was not alarming when the surveyor and herself were in the room. Observation on 09/11/25 at 8:01 A.M., of Resident #5's room revealed Restorative Aide #800 was providing services to Resident #5. The motion detector was not alarming. The Restorative Aide (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported she did not touch the motion detector. RN #552 entered Resident #5's room during observation and confirmed the motion detector was turned on but not functioning. Observation on 09/11/25 at 9:28 A.M., of Resident #5's room with Maintenance Director (MD) confirmed the motion detector was on however it was still not functioning. The MD reported he was not aware the motion detector was malfunctioning, and he would replace the detector. 2. Review of Resident #8's medical record revealed an admission date of 04/14/16, a re-entry date of 02/03/25 and diagnoses including, but not limited to, schizoaffective disorder bipolar type, hypertension, paroxysmal atrial fibrillation , anemia, anxiety, major depressive disorder, and unspecified intellectual disabilities. Review of Resident #8's significant change Minimum Data Set (MDS) assessment, dated 08/12/25, revealed a Brief Interview for Mental Status (BIMS) score of nine, out of a possible score of 15, indicating the resident had impaired cognition. The resident used a wheelchair for mobility and required supervision for wheelchair use. An observation on 09/08/2025 at 3:30 P.M. revealed Resident #8 was seated in a manual wheelchair with the vinyl of the top left hand side of the seat back cracked and torn and the inner padding of the wheelchair seat back visible, where it attached to the metal frame of the wheelchair. The tear was about an inch long. An observation on 09/11/2025 at 8:40 A.M. revealed Resident #8 was seated in a manual wheelchair with the vinyl on the of the top left hand side of the seat back cracked and torn and the inner padding of the wheelchair seat back visible, where it attached to the metal frame of the wheelchair. The tear was about three inches long. In an interview on 09/11/2025 at 8:45 A.M. Licensed Practical Nurse (LPN) #564 verified Resident #8 was seated in a manual wheelchair with the vinyl on the of the top left hand side of the seat back cracked and torn and the inner padding of the wheelchair seat back visible, where it attached to the metal frame of the wheelchair.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of resident counsel minutes, observation, interviews, and policy review the facility failed to ensure residents received adequate hydration and changes in nutritional status were addressed timely. This affected two (Resident #9 and #12) of two reviewed for hydration and two (Resident #12 and #38) of eight reviewed for nutrition. The facility census was 66. Findings include: 1. Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Ogilvie's syndrome, bipolar, depression, anxiety, chronic obstructive pulmonary disease, type two diabetes mellitus, Parkinson disease, heart failure, muscle weakness, need for assistance with personal care, lack of coordination, muscle wasting and atrophy, encephalopathy, tremors, dementia, anemia, fatigue, heart disease, heartburn, gastric reflux, and hemiplegia. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] revealed the resident had moderate cognition impairment, required supervision or touching assistance with eating. The resident was a therapeutic mechanically altered diet and had no signs or symptoms of swallowing difficulties. Review of Resident #12's alteration in nutrition and hydration plan of care dated 10/13/22 revealed monitor weights, monitor of signs and symptoms of dehydration, offer alternative fluids, offer meal substitutes when foods are refused, provide assistance with meals/snacks, registered dietitian and speech referral as needed. Review of Resident #12's orders dated 09/20/25 revealed the resident was ordered a low concentrated sweet and no added salt mechanical soft texture diet with thin consistency fluids. Two handled cups and built-up utensils for meals since 04/25/25. a. Observation on 09/08/25 9:58 A.M. of Resident #12 revealed the resident was in bed and had no fluids available. Interview with Certified Nursing Assistant (CNA) #554 confirmed findings and reported the resident was on fluid restriction in the past but she was not sure about now. Observation on 09/09/25 at 12:32 P.M., of Resident #12 revealed the resident was in a low bed with one side of the bed against the wall and a floor mat on the other side of the bed asleep. The resident 's bedside table was across the room with a Styrofoam cup however it was not in the resident 's reach. Observation on 09/10/25 at 8:41 A.M., 11:23 A.M., and 2:21 P.M., of Resident #12 revealed the resident was in bed. The resident had Styrofoam cup, however no straw in the cup. Observation on 09/11/25 at 9:07 A.M., of Resident #12 revealed the resident was in bed. The resident had a Styrofoam cup on the bedside table that was located across the room not in the resident 's reach. The cup had little ice but no water. Registered Nurse (RN) #552 confirmed the resident was non ambulatory and would not be able to reach the cup that was on the bedside table across the room. The RN confirmed the cup only contained a small amount of ice and no water or straw. The RN confirmed the resident was ordered handled cups for meals but was not sure why she had foam cup in her room and not handled cups. Interview on 09/11/25 at 9:54 A.M., with CNA #553 revealed she was usually assigned to Resident (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#12's hall. The CNA reported the resident was not ambulatory and would require the bedside table to be near her bed to reach fluids. The CNA reported that the resident can use foam cups with straws, however for meals the resident receives handled cups due to her tremors and risk of spilling the fluids. Interview on 09/11/25 at 11:26 A.M., with Registered Dietary Technician (RDT) #600 revealed the facility doesn't monitor fluid intakes and she assumes the fluid provided to Resident #12's via meal [NAME] and the twenty ounces that were provided during water/ice pass each shift would meet the resident needs. The RDT confirmed she had no documented evidence to ensure the resident was receiving adequate hydration. The RDT confirmed she was not aware there as issues with ice water not being passed on dayshift per the resident council meeting the last two months. b. Observation on 09/08/25 at 9:59 A.M., of Resident #12 revealed the resident was lying in bed with large pieces of pancakes lying on her chest and abdomen. The residents ' breakfast [NAME] was no present in the room. Review of Resident #12's weights on 09/08/25 revealed on 08/07/25 the resident weighed 207.2 pounds and 09/05/25 192.2 pounds indicating a 12.2-pound weight loss (7.2%). There was no evidence that the resident was re-weighed. Review of Resident #12's medical record on 09/08/25 revealed no evidence an intervention was implemented, the resident, family, or provider was notified of significant weight loss that was noted on 09/05/25. Interview on 09/08/25 at 4:57 P.M., with Resident #12's brother revealed the staff don't encourage Resident #12 to get up for meals or assist her with meals. Resident #12's brother reported he had voiced concerns to the facility, however every time he visits the resident was in bed and he has to assist her with meals to get her to eat. Interview on 09/11/25 at 9:54 A.M., with CNA #553 revealed the resident usually eats in her room and doesn't require much staff assistance. Interview on 09/11/25 at 11:26 A.M., with Registered Dietary Technician (RDT) #600 revealed she typically only visited the facility weekly on Wednesday and Fridays. RDT #600 confirmed she was responsible for entering weights into the electronic medical record and notify the providers of weight gains or loss. The RDT reported she was not aware of Resident #12's significant weight loss until 09/09/25. This week she had been in the facility daily due to the dietary manger being on vacation. The RDT reported she was trained she had seven days to address significant weight loss and seven days to notify the provider. The RDT confirmed the facility did not have a policy regarding the seven-day notification and it was just part of her training. The RDT reported if weights were obtained on Friday after she left, she would not address them until the following Wednesday when she returned to the facility. The RDT reported when she entered the weights into the electronic medical record she changed the date to reflect the date the weight should have been obtained. The RDT confirmed there was no documented evidence the resident was re-weighed after 09/05/25 to ensure the weight was accurate. The RDT reported usually, a second weight should be obtained within 24 hours to confirm accuracy. The RDT confirmed Resident #12 had a significant weight loss on 09/05/25, however she did not notify the doctor or implement new interventions for Resident #12 until 09/09/25. The RDT reported she had requested the staff to re-weigh the resident today for accuracy. The RDT confirmed she had not observed the resident eating a meal or interview the resident at this time. She had spoke (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the Administrator and Director of Nursing on Monday regarding the resident and ensuring the resident was up for all meals however she never documented or notified the floor staff of the recommendations. The RDT reported she had talked to speech this morning regarding a referral. The RDT confirmed there was no documentation the resident had refused to be weighed, or the resident had skin alterations. The RDT reported that the resident was on ProSource daily and she increased it on 09/09/25 to three times daily due to the resident was accepting the ProSource prior and it was the least amount of fluids with high concentration of protein and calories. The provider accepted the recommendation on 09/10/25 to increase the ProSource. Interview on 09/11/25 at 12:08 P.M., with Director of Nursing (DON) #512 revealed she had overheard the conversation with RDT #600 indicating the resident had not been re-weighed after 09/05/25 to the surveyor and she wanted to provide documented evidence the staff had re-weighed Resident #12 on 09/09/25. The DON showed the surveyor on her phone documented evidence the RDT was notified of the re-weight on 09/09/25 of 195 pounds. Interview on 09/11/25 at 12:50 P.M., with RDT #600 revealed the DON had brought it to her attention that the resident was re-weighed on 09/09/25 and she had entered the weight today, however the documentation would indicate it was added on 09/09/25. Interview on 09/15/25 at 9:58 A.M., 11:15 A.M., and 12:08 P.M. with Registered Dietician (RD) #602 confirmed the RDT was responsible for entering weights and the electronic medical record and notifying family and the providers. The RD reported the RDT was only in the facility twice weekly because she had other facility's she visited. The RDT usually provided the facility with a list of residents that needed weighed. The RD reported part of the nutritional assessment should include interviews with staff, families, and residents as well as observation of meal intakes. The RD reported the RDT had other homes to provide care for, and she believed a week to address significant weight loss was acceptable. The RDT confirmed the facility's policy did not include a timeframe on weighing nor did the facility have any policy on nutritional assessments. The facility utilizes a systemic approach to optimize each resident's nutritional status. The process may include identifying and evaluating nutritional status and risk factors, developing and implementing pertinent approaches, monitoring the effectiveness of interventions and revising them as necessary. A comprehensive nutritional assessment is completed upon admission to identify those at risk for unplanned weight loss/gain or compromised nutritional status. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional needs, including the resident's personal goals and preferences. Intervention are implemented, monitored and modified, consistent with the residents' assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. A weight monitoring schedule is developed upon admission for all residents. Newly recorded weights are compared to the previous recorded weights. A significant weight change was defined as 5% change in one month and 10% change in six months. Significant changes in weight are reported to the practitioner. 2. Review of the medical record of Resident #09 revealed admission to facility on 06/17/23 for diagnosis including moderate protein-calorie malnutrition, Alzheimer's disease, depression, bipolar, schizoaffective disorder (paranoid thoughts), diabetes, pain, anxiety, history of falls, parkinsonism (tremors of extremities and balance problems), and atrial fibrillation (irregular heart rate). Review of the most recent quarterly Minimum Data Set 3.0 (MDS 3.0) dated 06/23/25 revealed (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cumberland Pointe Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 68637 Bannock Road St Clairsville, OH 43950	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #09 was admitted to hospice services. Further review of the MDS 3.0 revealed the brief interview of mental status (BIMS) indicated Resident #09 had a score of 00/15 indicating severe cognitive impairment. MDS 3.0 indicated Resident #09 required meal set up and supervision with feeding self and was able to walk independently with supervision. Review of the physician orders summary revealed Resident #09 was prescribed a regular diet with thin liquids. Further review of order summary revealed Resident #09 was prescribed a 1500 milliliter (ml) fluid restriction that was discontinued on 02/14/25 by the physician. Review of the hospice care plan dated 06/16/25 through 09/13/25 revealed Resident #09 was on thin liquids with no fluid restriction ordered. Observation on 09/10/25 at 8:39 A.M. of Resident #09 revealed the resident was sleeping in their room with no fluids on their bedside table noted. Observation on 09/10/25 at 2:55 P.M. of Resident #09 revealed the resident was sleeping with music playing in their room and the lights out. There was a Styrofoam cup on the bedside table with orange colored drops of fluid on it and a 240 ml unopened can of cola. The bedside table was on the opposite side of the room from the resident while in bed and not within reach of Resident #09. Interview on 09/10/25 at 9:58 A.M., with Certified Nursing Assistant (CNA) #554 confirmed Resident #09 did not have fluids available and believed the resident was on fluid restriction in the past but not sure about now. Interview on 09/10/25 at 9:13 A.M. with CNA #553 revealed Resident #09 had not been feeling well and the last two days she was incontinent of urine, sleeping more, and talking less. Interview on 09/10/25 at 3:00 P.M. with RN #544 revealed the CNAs and Nurses pick up resident trays after meals and record meal consumption percentage in the medical record but do not record fluid intake. Interview on 09/11/2025 at 09:33 A.M. with Registered Diet Technician (RDT) #600 revealed the facility resident diet list is printed weekly on Mondays. RDT #600 further verified the diet list printed on 09/08/25 indicated Resident #09 was on a regular diet with a fluid restriction of 1500 ml per day allowing for 720 ml per day to be provided from the kitchen on meal trays the resident received during the day and 780 ml to be provided by nursing staff at bedside. Review of the lunch ticket for Resident #09 revealed 1500 ml fluid restriction with 240 ml to be provided at lunch. RDT #600 verified the lunch ticket indicated a 1500 ml fluid restriction and 240 ml of allotted fluids for the lunch meal. Interview on 09/11/25 at 9:40 A.M. with CNA #507 revealed she was unsure of which residents on the 100 hall were on fluid restriction and she believed it was one or two residents, but she would get further clarification. CNA #507 returned and reported she went to the kitchen and checked the master diet list and verified with the RDT #600 that Resident #09 was one of two residents on the 100 floor with a fluid restriction. CNA #507 reported she tried to pass water and ice twice a shift but definitely did it at least once every shift and as needed if residents requested. Interview on 09/11/25 at 9:55 A.M. with RN # 552 revealed Resident #09's care plan indicated a (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regular diet with thin liquids and no fluid restrictions. RN #552 verified Resident #09's fluid restriction was discontinued in February of 2025. RN #552 reported that Resident #09 had been sleeping more and less active for the past two days and hospice had increased services to daily RN visits for three days in a row to monitor. Interview on 09/11/25 at 11:26 A.M., with Registered Dietary Technician (RDT) #600 confirmed the meal ticket was inaccurate and Resident #09 was not currently ordered a fluid restriction. The RDT confirmed the fluid restriction order was discontinued back in February of 2025 and didn't know why it was not removed from the resident meal ticket. The RDT confirmed the meal ticket was updated and she notified staff the resident was not on fluid restriction. Interview on 09/11/25 at 1:08 P.M. with the primary hospice nurse revealed the resident was on a pleasure diet and currently had no fluid restrictions. The hospice aides would offer and encourage fluids during their time spent with the resident. Review of Resident Council meeting minutes dated July and August of 2025 revealed residents voicing concerns about day shift not passing ice and fresh water and they only get it on night shift. The facility response action taken section of the memo dated 08/11/25 included auditing CNA two times a week for ice water pass for two weeks and addressing any concerns as needed. 3. Review of the medical record for Resident #38 revealed an admission date of 08/12/25 . Diagnoses included but were not limited to subacute osteomyelitis, right ankle and foot; type 2 diabetes with foot ulcer; muscle weakness; type 2 diabetes mellitus without complications; unspecified asthma; other abnormalities of gait and mobility, unspecified systolic (congestive) heart failure; obstructive sleep apnea; hereditary and idiopathic neuropathy; anxiety disorder; bipolar disorder; essential hypertension; hyperlipidemia; pain; unspecified atrial fibrillation; gastroesophageal reflux disease; chronic rhinitis; constipation; personal history of malignant melanoma of the skin; personal history of transient ischemic attack and cerebral infarction without residual deficits; hereditary motor and sensory neuropathy; post traumatic stress disorder. Review of medical record for Resident #38 revealed a care plan, dated 08/16/25, which indicated a focus was initiated for nutrition and hydration related to nutritional risk, diabetes, congestive heart failure, gastroesophageal reflux disease, presence of diabetic ulcer and pressure ulcer. The interventions for the nutrition and hydration focus item included a Registered Dietician referral as needed. An update of this care plan on 09/01/25 indicated the facility was to provide supplement as ordered. Review of the medical record for Resident #38 revealed a malnutrition risk assessment, dated 08/18/25. The assessment was completed by Registered Dietary Technician (DTR) #600. The assessment revealed the resident scored a 10.0, which indicated the resident was at moderate risk for malnutrition. Review of the most recent Minimum Data Set (MDS) 3.0 assessment, dated 08/19/25, revealed a Brief Interview for Mental Status (BIMS) of 15. A BIMS score of 13 to 15 points indicated cognitive intactness. The resident was identified as using a motorized wheelchair prior to admission. On admission, Resident #38 was reported to be using a walker, requiring supervision or touch assistance to eat, for upper body dressing, and for personal hygiene. She required setup or clean-up assistance to perform oral hygiene, substantial/maximal assistance for lower body dressing, and was dependent in toileting and bathing. The MDS also indicated the resident was on a therapeutic diet. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #38 revealed an initial dietary assessment, dated 08/18/25, which indicated the resident was at moderate risk for decline in nutrition or malnutrition as evidenced by the malnutrition risk assessment. The assessment, completed by DTR #600, recommended Prosource (a ready to serve concentrated liquid protein) 30 milliliters (mL) twice daily, which, according to the assessment would provide 200 kilocalories and 30 grams of protein to the resident daily. Review of the medical record for Resident #38 revealed an order for Prosource, dated 08/29/25. The order was for the resident to receive Prosource 30 mL twice daily. Review of the medical record for Resident #38 revealed on 08/13/25, the resident weighed 197 pounds (lbs). On 09/05/2025, the resident weighed 187 lbs., which was a -5.08% loss. A 5% weight loss in one month indicated severe weight loss. On 09/11/2025 at 10:23 A.M., an interview with Director of Nursing (DON) #502 revealed once DTR #600 completed a dietary assessment, any recommendations would be sent via email to DON #502 for follow up with the physician. She indicated she received an email from DTR #600 on 08/28/25, which said Resident #38 required Prosource 30 ml twice daily. Review of an email from DTR #600, dated 08/28/25 at 10:30 P.M., to DON #502, which confirmed these findings. On 09/15/25 at 9:45 A.M., an interview with Dietician #602 revealed her expectation for dietary assessments and follow through with recommendations would be two days. She indicated the Registered Dietary Technician (RDT) would complete assessment on admission, send a text to the nurses, and the nurses would take care of the orders with the doctor. She indicated the follow up from day of assessment should be within a week, however she also indicated significant weight loss (5% in one month, 7.5% in three months, or 10% in six months) should be addressed within two days. On 09/15/2025 at 10:38 A.M., an interview with DTR #600 confirmed there had been a 10 day delay between the date the nutritional assessment for Resident #38 was completed to when recommendations were relayed to nursing. She confirmed the nutritional assessment was completed on 08/18/25, recommendations were not sent to nursing until 08/28/25, and an order was entered on 08/29/25 for Prosource 30 mL twice daily. Review of the facility's policy titled Weight Monitoring dated 02/15/24 revealed based on the resident's comprehensive assessment, the facility would ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicated otherwise.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, review of manufacture guidelines, and policy review the facility failed to provide post-inhaler care per guidelines to prevent potential complications due to use. This affected one resident (Resident #22) of two residents observed for medication administration. The facility census was 66. Findings Include: Review of the medical record for Resident #22 revealed an initial admission date of 06/29/18 with diagnosis including tumor of kidney, lung disease, heart failure, stroke, difficulty swallowing, weakness, moderate intellectual disability, epilepsy, high blood pressure, and depression. Review of Resident #22 physician order summary for September 2025 revealed an order for QVAR Redihaler 80 micrograms (mcg) inhale one puff twice a day. On 09/09/25 at 7:55 A.M. Licensed Practical Nurse (LPN) #544 was observed to prepare medications, including the QVAR Redihaler for Resident #22. On 09/09/25 at 8:04 A.M. LPN #544 was observed to administer the oral medications to Resident #22. The resident was observed to drink four ounces of water provided, following the medications. LPN #544 handed Resident #22 the QVAR inhaler to self-administer. Resident #22 shook the inhaler then inhaled one puff of the inhaler medication as ordered. Resident #22 gave the inhaler back to LPN #544. Resident #22 was not observed to rinse his mouth following use of the inhaler and LPN #544 did not advise the resident to rinse his mouth after the inhaler use. Review of the medication administration record for September 2025 revealed instruction for the resident to rinse their mouth with water and do not swallow the water after using QVAR Redihaler. Interview on 09/09/25 at 9:53 A.M. with LPN #544 confirmed she did not advise or instruct Resident #22 to rinse his mouth after the inhaler was used and stated, he will do it later. Review of the Teva (manufacturer) medication information insert (located with the inhaler inside the medication box) for the QVAR Redihaler revealed warnings and precautions on page one as follows, oropharyngeal candidiasis infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity. Advise patients to rinse their mouth with water without swallowing after inhalation to reduce risk.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on staff observation, record review, staff interviews, and policy review the facility failed to prepare and administer medications in a sanitary manner for Resident #55. This affected one (Resident #55) of two residents observed for medication administration. The facility census was 66. Findings include: Review of medical record review for Resident #55 revealed admission to facility on 08/21/22 for diagnosis including: chronic lung disease, vascular dementia (narrowing of blood vessels in brain leading to forgetfulness and confusion), bipolar disorder, diabetes mellitus, major depression, difficulty in walking, high blood pressure, weakness, and low back pain. Further review of the medical record revealed physician orders for Farxiga (diabetes medication) 10 milligrams by mouth daily in addition to other medications to be administered in the morning for Resident #55. Observation on 09/09/2025 at 7:35 A.M. of Registered Nurse (RN) #541 revealed the nurse prepared medication for Resident #55. The RN was observed to drop the Farxiga directly on top of the medication cart and using her bare hand, picked up the pill from the medication cart and placed the pill in the medication cup to be administered with other medication. Once preparation of medications was completed, RN #541 was observed to administered the medications to Resident #55. Interview on 09/09/2025 at 7:44 A.M. with RN #541 confirmed she picked up the Farxiga pill after dropping it on the medication cart and placed the pill in the medication cup using her bare hand. and administered the medication to Resident #55. RN #541 reported she should have gotten a new Farxiga pill but did not. Review of the Medication Administration Policy dated 06/21/2017 revealed all tablets and capsules are to be poured into the medication cup. Never touch medication with fingers.		