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	10/03/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of the facility Payroll Based Journal (PBJ) submission data for the third quarter of 2024, review of the facility assessment, review of medical records, review of shower sheets, 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 five residents (#16 , #25, #27, #31, and #52) and had the potential to affect all 62 residents residing in the facility. Findings include: 1a. Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, dysphagia, muscle weakness, dyspnea, contractures of right and left upper arm muscle, right and left foot drop, contractures of right and left knee, Ogilvie syndrome, dry mouth, quadriplegia, pain, and history of falling. Review of a social service note dated 09/25/24 revealed the resident can make his wants and needs known. He has a BIMS of 15. Review of Resident #27's minimum data set (MDS) assessment dated [DATE] revealed no behaviors including rejection of care. The resident was dependent on staff for self-care and had impairment of range of motion on both upper and lower extremity. Review of Resident #27's activities of daily living (ADL) plan of care dated 10/18/23 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 quadriplegia, chronic obstructive pulmonary disease, physical limitation, weakness, hard of hearing, congestive heart failure, contractors, and respiratory failure. The resident refuses showers at times. Review of the shower schedule revealed the resident was scheduled for shower on Monday, Wednesday, and Friday. Review of the paper shower sheets, and electronic medical record revealed no evidence the resident received a shower on 09/25/24. Review of Resident #27's progress notes dated 09/01/24 to 10/03/24 revealed no evidence of refusals of a shower/bath on 09/25/24. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/03/24 2:36 P.M., with Resident #27 confirmed he did not get a shower one day last week and was told it was because a staff member had called off and there wasn't enough staff. The resident reported lately there hasn't been enough staff, and the facility keeps sending staff home due to low census. The resident also reported he required more assistance because he can't use his hands, so he has to call for assistance to even get a drink of water. The resident reported on Monday (09/30/24) he did refuse his shower because he was nauseated and sick, but he did not refuse last week. Interview on 10/03/24 at 2:55 P.M., with the Director of Nursing #101 and #102 confirmed there was no documented evidence Resident #27 had received a shower on 09/25/24, however it was not related to staffing shortage. The facility had a call off that day, but the call off was covered. The facility felt it was a communication issue and the aides were provided education. b. Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including heart failure, muscle weakness, dysphagia, need for assistance with personal care, adult failure to thrive, dementia, pain, anxiety, and shortness of breath. Review of Resident #31's Minimum Data Set (MDS) assessment dated [DATE] revealed no evidence the resident had behaviors including rejection of care. Review of Resident #31's assistance with activity of daily living plan (ADL) of care dated 04/18/22 and revised 07/17/22 revealed the resident may require assistance with ADL and may be at risk for developing complications associated with decrease ADL self-performance, weakness, unsteadiness, needs assist with personal care, adult failure to thrive, dementia, without behavioral disturbances, pain, shortness of breath, experiences behavioral episodes at times. Participation levels may vary day to day, time of day or situation. Refuses to get out of bed most days. Interventions included assist as needed for grooming (nails/shave/hair). Monitor decline in care and report to clinical staff as needed. Review of Resident #31's progress notes dated 07/01/24 to 10/03/24 revealed no evidence of refusal of care. Review of Resident #31's task for nail care dated 09/03/24 to 10/03/24 revealed the last time the resident received nail care was on 09/26/24, however the task did not include what type of nail care was provided. Review of Resident #31's paper shower sheets for the month of September 2024 revealed the resident had a bed bath and nail care on 09/06/24. There was no documented evidence the resident received nail care on the paper shower sheets after 09/06/24. Interview and observation on 10/03/24 at 9:55 A.M., revealed Resident #31 was sitting up in a wheelchair watching television. The resident's hair was not combed and was laid flat on the back of her head. The resident's nails were long and jagged and most of her fingernails had a brown substance under them. The resident reported her nails needed trimmed and cleaned because she didn't have anything long enough to clean under her nails since they were so long, and her hair needed fluffed. The resident reported she already had her bed bath this morning because she doesn't like showers. The resident reported the facility didn't have enough staff to meet her needs including assisting with ADL's (hair and nails) and answering call lights timely. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and observation on 10/03/24 at 10:15 A.M. of Resident #31 with Licensed Practical Nurse (LPN) #200 confirmed the resident's nails were long and had a dark substance under her nails and her hair needed combed/fluffed. The LPN stated she would have staff come in and trim and clean the resident's nails and fluff her hair. c. Medical record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, bipolar, schizoaffective disorder, diabetes, drug-induced tremors, and atrial fibrillation. Review of Resident #16's ADL plan of care revealed the resident may require assistance with ADL's due to cognitive impairment, disease process/condition, mood/behavior problems, Alzheimer's disease, bipolar, diabetes, restlessness/agitation, tremors, pain, and anxiety. Participation levels may vary day to day, time of day, or situation related to cognitive deficit. Normal fluctuations in her mood/behavior may affect her participation levels and continence. Bathing assistance needed and dependent at times. The resident prefers a shower. Review of the shower schedule (undated) revealed the resident shower days were Thursday and Sunday. Record review revealed no evidence Resident #16 had refused showers the month of September 2024. Review of Resident #16's electronic medical record (bathing task) dated 09/03/24 to 10/03/24 revealed the resident did not receive a shower on 09/29/24. Review of paper shower sheets for September 2024 revealed no evidence Resident #16 received a shower/bed bath on 09/29/24. Observation of Resident #16 on 10/03/24 at 3:40 P.M., with Registered Nurse (RN) #134 at 3:40 P.M. confirmed the resident's fingers nails were clean but jagged. Interview on 10/03/24 at 3:46 P.M. and 4:24 P.M., with State tested Nurse Aide (STNA) #200 confirmed on 09/29/24 she was not able to perform a shower for Resident #16 due she was the only STNA on the floor that day and there was a resident fall that day and she was still new and still wasn't comfortable to be on her own. She did wash the resident's face and hands (partial bath). The STNA reported she doesn't feel there is enough staff to provide ADL care such as showers and nail care. The STNA confirmed the facility has been sending staff home due to low census and she had been usually the one sent home since she was just hired. The STNA reported she feels there needs to more than one STNA on the secured unit. She had volunteered to stay and help to noon, however, was told no and sent home. The STNA confirmed the facility asked her to fill out a shower sheet today (10/03/24) for 09/26/24. Interview on 10/03/24 at 4:22 P.M. with DON #101 revealed the facility found a shower sheet for 09/29/24 that indicated the resident had a bed bath. The DON did not know where the ADON found the shower sheet due to it was not in the folder with September's shower sheets when the surveyor reviewed all the resident shower sheets for September. d. During the onsite investigation, interviews with additional residents revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/03/24 at 1:29 P.M., with Resident #52 revealed there was not enough staff at times. It takes staff 1/2 hour to answer call lights. The weekends were worse due to staff call offs. Interview on 10/03/24 at 1:45 P.M., with Resident #25 revealed there isn't enough staff at times. It takes staff 25-30 minutes to answer his call light. There was no particular shift. e. During the onsite investigation, interviews with staff from 7:05 A.M. to 4:29 P.M. revealed the following: Interview with Staff Member (SM) #154 confirmed there was not enough staff to meet the residents needs including providing showers and nail care. Staff were being sent home due to low census. Staff have volunteered to come in and help and are told no. Interview with SM #148 confirmed there was not enough staff to meet the resident needs. The SM reported residents were not provided incontinence care timely, screaming to get up, call lights not answered timely, and not enough staff to supervise residents to prevent falls. Interview with SM #138 confirmed there was not enough staff to meet the resident needs. The facility was pulling staff to work other buildings or sending them home due to low census. The SM reported showers were not being done, nail care not being performed, call lights were not answered timely, and there was not enough staff to supervise to prevent falls. Interview with SM #201 revealed yesterday and over the weekend there was not enough staff on the secure unit to meet the resident's needs. There was only one nurse and one STNA which was not enough staff to supervise the residents on the secure unit. There was two residents that have fallen and required increased supervision. The facility was sending staff home according to the census and not considering the acuity required to provide care to the residents. f. 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. Interview on 10/03/24 at 8:34 A.M., with DON #101 confirmed the facility was sending staff home due to low census. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/03/24 at 12:07 P.M., with the Administrator revealed the facility doesn't have a policy or procedure for staffing and the facility would follow the facility assessment. The Administrator reported she was not aware of PBJ results from last quarter. She was currently responsible for the schedule. The Administrator reported staffing levels depended on the census. She tries to schedule three nurses on dayshift and two on nightshift, four to five STNA's on day shift and four on night shift. On the schedule some days there are staff with Asterix (*) that indicate the staff member could be mandated for a certain number of hours to cover call off's if needed. The STNAs were union and in the contract if they call off in the past three months they can be put on the mandating list. If there was a call off, they try to replace the call off depending on the census if it needs replaced. If someone was mandating that day, they will stay over to cover the approved number of hours. If no one was on the mandating list or will come in management staff will come in and work. The facility has no open nursing shifts and two STNA day shifts just opened up in the last 2 weeks. One STNA went to as needed and one resigned. g. Review of the facility PBJ submission data (staffing data submitted to the Centers for Medicare and Medicaid) revealed the facility was identified to have excessively low weekend staffing during the third quarter (April through June 2024) of 2024. This deficiency represents non-compliance investigated under Complaint Number OH00157948.