

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Salem Home		STREET ADDRESS, CITY, STATE, ZIP CODE 704 S Ash Street Hillsboro, KS 67063	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46960</p> <p>The facility census totaled 44 residents on two halls with a commons area where residents gathered for meals and activities. The facility had two medication carts and a nurse treatment cart. Based on observation, interview, and record review, the facility failed to provide a safe environment for nine residents by the failure to ensure a nurse treatment cart that contained insulin (a medication used to treat diabetes [a disease when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin]) remained locked when not in direct line of vision of the nurse.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 08/06/24 at 11:19 AM, a treatment cart on the 200 hall observed unlocked and unattended. <p>On 08/06/24 at 11:20 AM, Licensed Nurse (LN) G confirmed the medication cart was left unattended and unlocked. LN G further confirmed that the cart serviced nine residents and contained insulin and general wound care supplies. LN G revealed that the medication cart should be always locked when unattended and stated that she failed to lock the medication cart before going the nurses' station. LN G identified two self-mobile and confused residents who lived in the 200 hall.</p> <p>On 08/06/24 at 11:25 AM, Administrative Nurse D stated the expectation was for all staff who have access to medication carts to lock the medication carts before walking away.</p> <p>The facility's Medication Administration Policy policy, dated 06/2024, documented that medication carts, including the nurse treatment carts, are to be locked when not in the direct line of sight of medical personnel.</p> <p>The facility failed to provide a safe environment for all residents by the failure to ensure a medication cart used by the facility remained locked when not in direct line of vision of the licensed nurse passing medications from their carts.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 175484	If continuation sheet Page 1 of 5

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28560</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>The facility reported a census of 44 residents. The facility identified two residents required pureed diets. Based on observation, interview, and record review, the facility failed to ensure pureed foods were prepared to ensure nutritional and flavor compatibility with the menu to enhance the dining experience for these two residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Observation, on 08/06/24 at 10:45 AM revealed Dietary Staff CC prepared pureed diet for two residents. The menu for the noon meal included beef soft taco with lettuce, cheese, tomato, sour cream, spanish rice, and fiesta corn. Dietary staff CC stated the facility form Mechanically Soft Level Two Diet indicated that staff should avoid corn or regular rice, so she substituted mashed beans (pork and beans) for the corn and mashed potatoes and gravy for the fiesta rice. Dietary staff CC stated she did not have a nutritionally equivalent substitute guide for the spanish rice or fiesta corn for pureed diets. <p>Interview, on 08/07/24 at 09:00 AM, with Dietary Staff BB confirmed that the facility had a computerized program for dietary substitutes but did not routinely use a pureed diet guide other than the posted Mechanically Soft (Level 2) Diet and a regular menu.</p> <p>Interview, on 08/07/24 at 09:30 AM, with Dietary Consultant GG, revealed the substitute for corn included pureed cream corn, and the fiesta rice included cream of rice, and various recipes for pureed rice. Dietary Consultant GG stated if foods are substituted, they should be nutritionally appropriate substitutes for pureed foods, and would provide the facility with the guidelines/menus.</p> <p>The facility guideline 4 Pureed dated January 2019, contained a list of foods to avoid and characteristics to avoid. The guide instructed the reader/staff to consult with a health care professional for specific advice for diet needs and the list was intended for general information only.</p> <p>The facility policy Blended and Pureed Meat Diets dated February 2023, instructed staff to follow the the regular menu and provide the consistency modification as ordered by the physician.</p> <p>The facility failed to provide pureed food substitutes nutritionally and with flavor compatibility with the menu to enhance the dining experience for two residents that required a pureed diet.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560</p> <p>The facility reported a census of 44 residents. Based on observation, interview, and record review, the facility failed to ensure foods were stored, prepared, and distributed in a manner to prevent foodborne illness to the residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Observation on 08/06/24 at 10:45 AM, revealed room trays for residents set with beverages. Two trays contained a glass of milk, and one contained a liquid nutritional supplement in a glass. <p>Observation, on 08/06/24 at 11:15 AM, revealed Dietary Staff DD, obtained the temperature a glass of milk on the tray and revealed a temperature of 60 degrees Fahrenheit (F). Dietary Staff DD stated the milk should be served at 41 degrees F, and the supplier delivered the milk earlier and may not have cooled down to 41 degrees F. Dietary Staff DD obtained two new glasses of milk from newly delivered milk from the refrigerator and revealed a temperature of 48 degrees F. Dietary Staff DD obtained the temperature of the nutritional supplement and revealed a temperature of 57 degrees F. Dietary Staff DD obtained a new nutritional supplement which had a temperature of 57 degrees F and stated the temperature should be 41 degrees and obtained a new nutritional supplement from the refrigerator which had a temperature of 42 degrees F. Dietary Staff DD stated the trays were usually set up 30 minutes before serving.</p> <p>Observation, on 08/06/24 at 11:20 AM, revealed Dietary Staff CC prepared to serve the residents their noon meal with dishware that contained worn colors and faded designs. Dietary Staff CC stated the entire service ware which included plates and bowls contained faded designs and worn areas.</p> <p>Observation, on 08/07/24 at 08:45 AM, during the environmental tour of the kitchen revealed the following areas of concern:</p> <ol style="list-style-type: none"> 1. Three air vents and ceiling above the stove area contained a black substance over multiple areas of various sizes. Interview with Dietary Staff BB, confirmed the areas and stated maintenance was responsible for cleaning the vents and ceiling. Interview with Maintenance staff U, revealed dietary staff was responsible for cleaning the vents and ceiling. Maintenance Staff U scrubbed the black areas and thought the substance may be accumulation of dust and grease. 2. The front surface of a wooden cabinet drawers which contained serving items, contained peeling varnish and a liquid stain. The serving items (four spatulas and two pizza wheels) contained brown/black substance in the surface grooves. The doors of the cabinet also contained areas of worn varnish and the inside shelves, which contained various service items, contained shelves with a black substance in the wood grain and peeling varnish. 3. The shelf beneath the double ovens contained grime and debris. 4. Two omelet pans contained a black substance around the interior sides. <p>(continued on next page)</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>46960</p> <p>The facility reported a census of 44 residents. Based on interview and record review, the facility failed to electronically submit complete and accurate staffing information to the Federal regulatory agency through Payroll-Based Journaling (PBJ) when the facility failed to accurately submit hourly staffing data for all nursing personnel.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the PBJ Staffing Data Report for Fiscal Year (FY) for Quarter 3 - 2023 (April 1 - June 30), the data indicated the facility failed to have Licensed Nursing Coverage 24 hours/Day on the following dates: 04/01/23 Saturday (SA), 04/09/23 Sunday (SU), 04/16/23 (SU), 04/29/23 (SA) and 05/13/23 (SA). <p>Review of the nursing schedule and payroll data sheets for the above dates revealed adequate hours to account for 24-hour nursing coverage.</p> <p>On 08/07/24 at 08:24 AM, Administrative Nurse D reported that payroll data and scheduling data reflected that 24- hour nursing coverage and that nursing staff were scheduled for either eight-hour or 12-hour shifts where no lunch was taken but the PBJ submission deducted a 30-minute period for lunch.</p> <p>The facility's Mandatory Submission of PBJ policy, dated 05/2024, documented that the facility would complete electronic and accurate submission of staffing information based on payroll data as specified in regulatory requirements.</p> <p>The facility failed to submit complete and accurate staffing information to the Federal regulatory agency through PBJ when the facility failed to accurately submit hourly staffing data for all nursing personnel.</p>		