

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45763 Based on observations and interviews, the facility failed to provide a dignified existence to residents. Specifically, the facility failed to ensure that staff did not refer to residents who require assistance as feeds or feeders, that staff did not speak in a foreign language to each other in the presence of residents, that staff did not stand while providing feeding assistance to residents, that staff did not transport a resident while he/she was facing backwards, and that a foley catheter drainage container was covered and wasn't visible from the hallway. Findings Include: Review of the facility policy, titled Quality of Life - Dignity, created in October 2022, indicated, but was not limited to, the following: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. - Residents shall be treated with dignity and respect at all times. - Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. - Residents shall be assisted in transporting throughout facility as needed. - Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. - Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered. On 7/24/24 at 8:37 A.M., the surveyor observed a staff member referring to two separate residents as a feed in a common area, within earshot of residents. (continued on next page)		

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

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Some	On 7/24/24 at 8:38 A.M., the surveyor observed a staff member referring to a resident as a feeder in a common area, within earshot of residents. On 7/24/24 at 8:45 A.M., the surveyor observed a staff member referring to two separate residents as a feed in a common area, within earshot of residents. On 7/24/24 at 8:57 A.M., the surveyor observed a staff member providing feeding assistance to a resident. The resident was in his/her bed, the staff member was standing over the resident and not at eye level with the resident. On 7/25/24 at 8:06 A.M., the surveyor observed a staff member transporting a resident in a wheelchair roughly 30 feet down the hall. The staff member was walking forwards while holding the wheelchair behind her back with one hand. The resident and the wheelchair were facing backwards, the surveyor observed the resident ask the staff member we're going backwards? and the resident sounded upset. On 7/25/24 at 8:43 A.M., the surveyor observed a staff member referring to a resident as a feed in a common area, within earshot of residents. On 7/24/24 at 8:50 A.M., the surveyor observed a staff member providing feeding assistance to a resident. The resident was in his/her bed, the staff member was standing over the resident and not at eye level with the resident. On 7/25/24 at 11:56 A.M., the surveyor observed three staff members speaking Spanish in a common resident area, there was a resident in between the three staff members. The surveyor observed the resident say, I don't speak Spanish. On 7/25/24 at 12:33 P.M., the surveyor observed two staff members speaking Creole within earshot of the dining room containing five residents. On 7/26/24 at 9:13 A.M., the surveyor observed a staff member providing feeding assistance to a resident. The resident was in his/her bed, the staff member was standing over the resident and not at eye level with the resident. On 7/26/24 at 12:58 P.M., the surveyor observed a staff member providing feeding assistance to a resident. The resident was in his/her bed, the staff member was standing over the resident and not at eye level with the resident. On 7/25/24 at 12:01 P.M. the surveyor observed a resident in bed, his/her catheter drainage container was uncovered and visible from the hallway. On 7/26/24 at 7:56 A.M. the surveyor observed a resident in bed, his/her catheter drainage container was uncovered and visible from the hallway. On 7/31/24 at 3:09 P.M. the surveyor observed a resident in bed, his/her catheter drainage container was uncovered and visible from the hallway. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Some	During an interview on 7/29/24 at 8:17 A.M., the Director of Nursing said that foley catheter drainage container should not be visible, that staff should not be speaking foreign languages to each other on the resident unit, that staff should not be referring to residents as feeders, that staff should be sitting and at eye level with the resident while providing feeding assistance, and that staff should not be transporting resident's down the hall while the resident is facing backwards.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0559 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on record review, policy review and interviews the facility failed to provide written notice, including the reason for the change, before the resident's room or roommate in the facility is changed for one Resident (#35), out of a total sample of 39 residents. Findings include: Review of the facility policy, titled Room Change, dated as revised 10/22, indicated changes in room or roommate assignment shall be made when the resident or their representative requests the change or the facility deems in necessary. The facility will attempt to limit room changes unless otherwise requested by the resident or the resident's representative. 3. When a resident room change is occurring, the resident being moved or their representative, will be informed of the room change. a. The notice of change in room or roommate assignment will be both verbal and in writing and will include the reason(s) for the change. Staff should complete a Room Change Notice and provide to the resident or their representative and be placed in the resident's medical record. Resident #35 was admitted to the facility in February 2024 with diagnosis including stroke affecting left side, diabetes, and chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/22/24, indicated that Resident #35 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Review of facility census, dated 6/4/24, indicated that Resident #35 moved from room on [NAME] Unit to a room on [NAME] Unit. Review of Resident #35's entire medical record, including interdisciplinary progress notes for June 2024, failed to indicate any reason for the room change or any written notification to Resident #35 or Resident #35's Resident Representative for the room change. During phone interview on 7/31/24 at 5:01 P.M., the invoked Health Care Proxy said she was not provided with written notice of the room change and had not been in the facility since the room change to determine how Resident #35 has adjusted to the change. During an interview on 7/31/24 at 2:00 P.M., the Social Worker shared Notification of Room Change form that is used to document notification. The Social Worker said this form should be completed and filed in resident's medical record but was unable to locate it. The Social Worker said he could not remember why Resident #35's room was moved. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0559 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 7/31/24 11:50 A.M., the Director of Nursing (DON) said Resident #35 and/or their Resident Representative should have been notified of any room change and it should have been documented in record. The DON said she cannot remember why Resident #35 moved units.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48990 Based on Resident Council Meeting minute review, interviews, and record review, the facility failed to ensure grievances addressed by the Resident Council Group had sufficient follow-up to prevent recurrence and provide residents with rationale for actions taken by the facility to resolve grievances. Findings include: Review of the facility's polity titled Resident Council, revised 1/2023, indicated: - Concerns that are raised at the meeting must be recorded in minutes and followed with a concern/response form filled out by the designated staff representative, and addressed to the corresponding Department Head to provide a resolution. All supporting documentation (i.e. in-services, staff education, clinical notes) must be attached. Concern/response forms must be completed within 7-days of being issued. During the Resident Group interview on 7/25/24 at 1:01 P.M., nine residents were in attendance and reported the following concerns: - 8 out of 9 residents reported staff are still on their phones and using ear buds when they should be providing care. - 6 out of 9 residents reported they still have a hard time getting in touch with social worker. - 9 out of 9 residents reported they have requested the Social Worker to attend Resident Council, but he hasn't come. - 8 out of 9 residents reported they continue to have food concerns. - 5 out of 9 residents reported they still have problem with laundry missing and they don't give us any answers when we report things missing. The Resident Group said these concerns have been reported for over three months and the Resident Council President gave the surveyor permission to review the past three months of Resident Council Meeting minutes. Review of Resident Council Meeting minutes, dated April 2024, indicated the following issues: - Nursing: Residents still have an issue with ear buds and cell phone usage by nursing staff. - Social Services: Complaints of never seeing or some never meeting the social worker, they don't feel there is enough communication form [sic] social services. Most of the participants are requesting that the social worker attends the next resident council meeting. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dietary: Food and coffee being served to them cold. Special requests from residents: fried chicken once per week and maybe some spaghetti and meatballs. Some residents are requesting access to coffee in the late afternoon. - Maintenance/housekeeping: Complaints of missing items after clothing is brought back from laundry. Review of the minutes failed to indicate the facility's response and rationale to grievances. Review of Resident Council Meeting minutes, dated May 2024, indicated the following issues: - Residents' request the attendance of Social Worker and Director of Nursing at the next resident council meeting. - Nursing (nurses and CNAs'): Cell phone and headphone usage is still happening more often than not. - Social Services: Resident's claim some of them have never met the social worker. They would like him to be more involved and attend some of the resident council meetings. Sometimes social worker will make plans with a date and time to meet with the residents and then doesn't show up. - Dietary: Food is always cold, sometimes coffee as well. Some menu changes/substitutions are not being honored. Most sandwiches are either soggy, or hard and old. Residents have 2 requests for the menu: more fried chicken and some spaghetti and meatballs sometimes. - Maintenance/laundry/housekeeping: A lot of residents are complaining about missing laundry and other items. Review of the Resident Council Meeting minutes failed to indicate the facility's response and rationale to all grievances. Review of section of Resident Council Meeting minutes titled Old Business failed to indicate any response to above concerns, except the following: - Social Worker was asked to be present at this meeting by the residents. However, he is on vacation so unable to attend. Review of Resident Council Meeting minutes, dated June 2024, indicated the following issues: - Nursing: Residents are still complaining about cnas [sic] and nurses using their phones for personal use while on the floor, and also while taking care of the residents. - The Director of Nursing (DON) and Social Worker were asked to be present at this meeting. However, both were unable to attend due to meetings and a shortage of nursing staff. - Social Services: Some residents claim they have never met the social worker. They were promised visits from this department, and it rarely happens. Would like more interaction with this department. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Kitchen/dietary: Wet sandwiches. Food still arriving to them cold. Breads and rolls are often burnt or undercooked (no happy medium or in between). A request is made for real eggs as the residents feel that the powdered or liquid eggs taste bad and aren't as nutritious. Resident's (lots of residents in the meeting and throughout the building) have requested real fresh fruit instead of canned fruit. A lot of complaints of stale breads/sandwiches or burnt/overcooked breads. Review of the Resident Council Meeting minutes failed to indicate the facility's response and rationale to grievances. Review of section of Resident Council Meeting minutes titled Old Business indicated failed to indicate any response to above concerns. During an interview on 7/29/24 at 8:40 A.M., the Activities Director said she gives each department head the Resident Council Meeting minutes after the meeting to follow up on concerns. The Activities director said concerns with staff cell phone usage, difficulty getting in contact with the Social Worker, food concerns, and missing laundry has been brought up the past three months and she had notified the department heads each month. The Activities Director said the concerns regarding the Social Worker had even been elevated to the corporate level, but nothing had been done to correct the issue. The Activities Director said it is their responsibility to resolve the issue and responses or rationale is not provided to the Resident Council Group. During an interview on 7/29/24 at 8:50 A.M., the Director of Nursing (DON) said she had been aware of the Resident Council concerns with staff cell phone and ear bud usage for over three months and had just had an in-service to address it two weeks ago. The DON said she never provided a response to the Resident Council Group. The DON said she knew her attendance had been requested at Resident Council Meetings but was too busy to attend. During an interview on 7/29/24 at 8:55 A.M., the Social Worker said the concerns for Social Services were not true and this was communicated to the Activities Director. The Social Worker said he did not provide a response or the rationale to the Resident Council Group because he expected the Activities Director to. The Social Worker said he knew his attendance had been requested at Resident Council Meetings but was too busy to attend. During an interview on 7/30/24 at 8:26 A.M., the Food Service Director (FSD) said he gets the Resident Council Meeting minutes each month and corrects the concerns. The FSD said he never provides a response to the Resident Council Group. During an interview on 7/30/24 at 11:05 A.M., the Administrator said Department Heads are expected to address any concerns identified by Resident Council Group. The Administrator said the response and follow-up had not been expected to be documented or written, but probably should be to ensure it was followed up on.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 48990 Based on interview and record review, the facility failed to allow residents privacy when opening packages. Findings include: Review of facility's policy titled Quality of Life - Dignity, dated 10/2022, indicated: - Staff shall promote, maintain, and protect resident privacy. During the Resident Group interview on 7/25/24 at 1:01 P.M., 4 out of 9 residents in attendance said they had a concern with not being allowed to open packages without supervision or having mail or packages delivered already opened. During an interview on 7/26/24 at 10:55 A.M., the Activities Assistant said the activities department is responsible for delivering packages to residents. The Activities Assistant said residents are not allowed to open packages without supervision because she needs to make sure they aren't ordering things they shouldn't have. During an interview on 7/26/24 at 11:10 A.M., the Activities Director said residents are not allowed to open packages without supervision because she had been told by administration that they need to check for contraband because of a past incident of a resident ordering illegal substances. The Activities Director said she feels this violates the residents' rights and invades privacy, but since she had been told by administration not to allow them to open packages without supervision, the department provides supervision opening all packages delivered to residents. During an interview on 7/26/24 at 11:30 A.M., The Administrator said packages should not be delivered already opened. The Administrator said staff supervises packages being opened because the facility is concerned about dangerous items, such as knives, being delivered. During a telephone interview on 7/29/24 at 10:56 A.M., the Ombudsman said a discussion was had with the facility previously addressing that having a mandatory facility wide policy of not allowing residents to open packages without supervision would be a violation of residents' rights.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) for one Resident (#62), out of a total sample of 39 residents. Specifically, for Resident #62, the facility failed to ensure that Advanced Directives (Massachusetts Medical Order for Life-Sustaining Treatment form (MOLST)) were consistently documented in the medical record. Findings include: Review of the facility policy, Advanced Directives- Basics, dated as revised ,d+[DATE], indicated that advanced directives will be respected in accordance with state law and facility policy. 3. In accordance with current OBRA definitions and guidelines governing advanced directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: b. Do Not Resuscitate - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used. Resident #62 was admitted to the facility in February 2024 with diagnoses including chronic kidney disease, diabetes, depression and obesity. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #62 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS was coded as the following: Do Not Resuscitate- NO, indicating that Resident #62 wishes for full code (attempt resuscitation) status. Review of Resident #62's MOLST, dated [DATE], indicated: - Attempt Resuscitation. Review of Resident #62's physician's order, dated [DATE], indicated: - Honor Most Recent MOLST - form in chart. Review of Resident #62's most recent MOLST, dated [DATE], indicated: - Do Not Resuscitate (DNR). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's plan of care related to advanced directives indicated he/she is electing full code status, dated [DATE] and most recently revised [DATE], indicated: - Follow MOLST form as ordered. During an interview on [DATE] at 3:57 P.M., Resident #62 said he/she wishes to be a full code and would want facility staff to attempt CPR on him/her. During an interview on [DATE] at 7:11 A.M., Nurse #11 said resident's code status are documented on the report sheets, and in the event of an emergency she would follow the most recent MOLST in the chart. The surveyor reviewed the unit report sheet which indicated Resident #62 was a full code. During an interview on [DATE] at 4:09 P.M., Nurse #13 said for Resident #62's code status he would refer to the actual copy of MOLST form in the medical record. During an interview on [DATE] at 9:09 A.M., the MDS Nurse said when completing MDS information she reviews the code status order in the electronic health record. The MDS Nurse said she documented the code status on the MDS information based on the electronic health record. However, the physician's order did not have a code status as part of the order and the order indicated review the MOLST. During an interview on [DATE] at 4:13 P.M., the Director of Nursing (DON) said upon return from the hospital nursing should have reviewed the MOLST in Resident #62's medical record. On [DATE] at 4:44 P.M., the surveyor and the DON reviewed Resident #62's medical record, and observed the two MOLSTs, and the most recent MOLST form indicated that Resident #62 was a DNR. The DON interviewed Resident #62 and Resident #62 said he/she wished for full code status. The DON said that the chart should have been reviewed during the most recent MDS review period on [DATE] and there shouldn't have been both MOLSTs forms readily available in the medical record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observations, interviews and record review, the facility failed to notify the physician of a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) and/or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for five Residents (# 85, #24, #88, #103 and #3) out of a total sample of 39 residents. Specifically: 1) For Resident #85, the facility failed to notify the physician of a new necrotic skin condition or of the Wound Physician's recommendations for wound care treatment leading to the skin condition progressing to an wound leading to osteomyelitis (a bone infection) and sepsis (a life-threatening response to infection) requiring hospitalization and need for a fecal-diverting colostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, that allows digested food to pass out of the body through an external pouch system). 2.) For Resident #24, who had four stage 4 pressure ulcers and one unstageable pressure ulcer, the facility failed to notify the provider of the consultant wound physician's recommendations and subsequently nursing did not obtain new physician's orders for wound care based on these recommendations. 3) For Resident #88, the facility failed to notify the provider of the change in wound condition and need to alter wound treatment. 4) For Resident #103, the facility failed notify the physician of new recommendations from the consultant wound practitioner for treatment of a stage IV pressure ulcer. 5) For Resident #3, the facility failed to notify physician of the change in wound condition and need to initiate wound treatment. Findings include: Review of the facility policy titled Pressure Wound Prevention, revised January 2023, indicated, but was not limited to, the following: Monitoring 1. Evaluate, report and document potential changes in the skin. 1) Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. Review of Resident #85's Potential Skin care plan, initiated 3/8/23, indicated the Resident had potential for alteration in skin integrity, with the following interventions: - Complete skin condition checks weekly. - Dietary interventions/evaluation. - Follow MD (Medical Doctor/physician) orders for skin care and treatments (utilize best practice guidelines). Review of Resident #85's Norton Scale for predicting risk for pressure ulcer, dated 2/27/24, indicated the Resident scored an eight, placing the Resident in the high risk category. Review of Resident #85's Skin Only Evaluation, dated 3/6/24, indicated Resident #85 had no skin issues. Review of Resident #85's Skin Only Evaluation, dated 3/11/24, indicated Resident #85 had a new necrotic (the death of body tissue or an organ due to a lack of blood supply) wound on the left buttock, medial area, and that the wound did not have an odor. Review of Resident #85's initial Wound Evaluation and Management Summary, dated 3/12/24, indicated the Wound Physician evaluated the Resident for a rash. The Wound Physician diagnosed Resident #85 with diaper dermatitis and recommended lotrisone cream (an anti-fungal cream) to be applied twice daily to the affected area and prn (as needed). Review of Resident #85's Treatment Administration Records failed to indicate that the lotrisone cream was implemented. During an interview on 7/29/24 at 10:03 A.M., Nurse #17 said that when changes in skin are identified they should be reported to the NP (Nurse Practitioner)/MD (medical doctor). Nurse #17 said that the Wound Physician will give recommendations to the staff member accompanying her during wound rounds every Tuesday. Nurse #17 said that a Certified Nursing Assistant had initially reported the wound to her, and that the Resident had a wound on the middle of the coccyx and a wound on the left buttocks; Nurse #17 said she had not reported the wound to the physician because the wound did not need the physicians' attention because of how small it was. Nurse #17 said she did not apply lotrisone, and that the aides have been using house barrier cream which was not a new treatment for the newly identified wound in March. During a follow-up interview on 7/30/24 at 8:19 A.M., Nurse #17 said that communication with the physician would be included in a progress note, and in the communication book. Review of the communication book and Resident #85's progress notes failed to indicate that the physician was notified of the new necrotic skin condition identified on 3/11/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Nurse practitioner (NP) progress note, dated 3/13/24, failed to indicate that the NP was aware of, evaluated, or initiated treatments for Resident #85's necrotic wound. Review of Resident #85's wound evaluation and management summary, dated 3/19/24, indicated the Wound Physician evaluated the Resident's rash. The Wound Physician recommended lotrisone cream for the diaper dermatitis. During an interview on 7/30/24 at 11:13 A.M., the Wound Physician said that when she is consulted, she does not do a full skin check due to time constraints. The Wound Physician said she was initially consulted for Resident #85 to evaluate a rash on the frontal groin area, and nothing else; as the rash was on the front she may not have evaluated the backside and she was not aware of a necrotic wound when she evaluated the rash. The Wound Physician said this may have been a result of bad communication. Review of Resident #85's Treatment Administration Records (TAR) failed to indicate that the lotrisone cream was implemented. Review of Resident #85's medical record failed to indicate a nursing skin evaluation was completed the week of 3/18/24. Review of Resident #85's physician orders indicated the following discontinued orders: - Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to Sacrum topically one time a day for Wound, initiated 3/23/24, 12 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 5/24/24. - Left butt wound wash with normal saline cover with silicone bordered form dressing every day shift left butt wound, initiated 3/22/24, 12 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 5/24/24. - Wound Consult for left butt wound, initiated 3/25/24, 15 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 4/25/24. Review Resident #85's progress note, written by NP #2, dated 3/26/24, indicated the following: I was asked to see this pt (patient) because of worsening wounds. Nursing reports they had started as superficial, but now were open and deeper. He/she had not been followed by the wound care team. Consult initiated and wound team saw this resident the AM of 3/26. They will now follow his/her wounds which are pressure related. Further review of Resident #85's progress note, written by Nurse Practitioner (NP) #2, dated 3/26/24, indicated that the consult for the Resident's wound was initiated 15 days after nursing had initially identified the necrotic area. Further review of the progress note indicated that the wound team requested multi-interventions in addition to wound care. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/30/24 at 11:42 A.M., NP #2 said she would expect to be notified of a new skin condition. NP #2 said that her review of systems includes communication with the nurses, and that she does not do a full-skin check as part of her regular evaluation; the NP said that she would only look at skin if a concern is brought to her attention. NP #2 said a staff member will follow the Wound Physician to communicate the recommendations to her, and that she would expect the recommendations to be implemented. NP #2 said that the risk of not implementing the Wound Physician recommendations would be that the wound could get worse, and that the wound could get infected and develop osteomyelitis. NP #2 said she was first notified of the wound on 3/26/24, when nursing reported to her that the wound had developed an odor, and that when she had evaluated the Resident on 3/13/24 she had not been aware of the wound. During an interview on 7/31/24 at 9:16 A.M., Physician #2 said he would expect nursing to notify himself or an NP of a change in skin condition. Physician #2 said a facility nurse should be following the Wound Physician for recommendations, and that the risk of Wound Physician recommendations not being followed would be that the wound would probably get worse if the Resident was not receiving treatment. Review of Resident #85's Wound Evaluation and Management Summary, dated 3/26/24, indicated Resident #85 had an unstageable (due to necrosis) pressure injury on his/her left ischium measuring 2.5 x 2.4 cm (centimeters), and an unstageable (due to necrosis) pressure injury on his/her sacrum measuring 3.9 x 3.7 cm. Further review of the wound evaluation indicated that the duration of both wounds was greater than six days, and that the Wound Physician recommended a house supplement (a calorically and nutritionally fortified drink typically utilized to address weight loss and/or meet assist in meeting nutrient, such as protein, needs) alginate calcium (a gel that promotes wound healing), and santyl (an ointment used to promote the healing of skin ulcers by removing damaged tissue). Review of the nursing progress note, dated 3/27/24, indicated Resident #85 was being transferred to emergency room for evaluation as the resident was very week [sic]. And oxygen of at 58% at room air. Review of Resident #85's Treatment Administration Record (TAR) failed to indicate that alginate calcium, or santyl were implemented prior to the Resident's hospitalization on [DATE]. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the hospital discharge paperwork, dated 4/22/24, indicated that Resident #85 presented to the hospital on 3/27/24 with encephalopathy (a broad term for any brain disease that alters brain function), found to be in sepsis with an infected sacral ulcer as the presumed source. Further review of the hospital paperwork indicated that the Resident underwent wound debridement (a procedure that removes unhealthy or dead tissue from a wound to promote healing and prevent infection) on 3/29/24, 3/31/24, 4/5/24, and 4/21/24, and that fecal diversion was indicated to allow for the wound to heal due to the wound's proximity to the anus; on 4/5/24 the Resident underwent a diverting loop sigmoid colostomy creation. The hospital paperwork indicated there was clinical and imaging evidence of osteomyelitis with the sacrum/coccyx bones exposed in the wound. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the nursing progress note, dated 4/22/24, indicated that Resident #85 had returned from the hospital with a sacral ulcer with underlying osteomyelitis status post multiple debridement's and the creation of a diverting loop colostomy. Further review of the progress note indicated that the Wound Physician would evaluate the Resident on 4/23/24 to provide guideline on wound vac (a treatment that uses suction to help wounds heal) use [sic]. Review of the Minimum Data Set (MDS) assessment, dated 4/28/24, indicated that Resident #85 scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated that Resident #85 had a new Stage IV and a new Stage III pressure ulcer and was at risk for developing pressure ulcers. According to the Mayo Clinic, complications and outcomes of Stage IV pressure ulcers include: - Osteomyelitis, which is characterized by a mixture of inflammatory cells, fibrosis, bone necrosis, and new bone formation. It is associated with nonhealing wounds, surgical flap complications, and an increased length of hospitalization . It may develop within the first 2 weeks of pressure ulcer formation and despite treatment may require amputation in lower extremity cases. - Joint infections (septic arthritis) can damage cartilage and tissue. - Bone infections (osteomyelitis) can reduce the function of joints and limbs. - Long-term, nonhealing wounds can develop into a type of squamous cell carcinoma. - Sepsis (blood infection). Review of the Wound Evaluation and Management Summary, dated 4/23/24, indicated that Resident #85 had a stage IV sacral pressure wound (Stage IV pressure wounds are defined as deep wounds that may impact muscle, tendons, ligaments, and bone) measuring 17 x 17 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement, foley catheter (a medical device that helps drain urine from the bladder) and negative pressure wound therapy (wound vac) to be applied three times per week for 30 days at 125 mmHg (millimeter of mercury, a manometric unit of pressure) continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated on 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 4/30/24, indicated that Resident #85 had a stage IV sacral pressure wound measuring 17 x 16.8 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement and negative pressure wound therapy to be applied three times per week for 23 days at 125 mmHg continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated on 4/22/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's progress notes indicated the Resident was transferred to the emergency roiaognom on [DATE]. Review of the hospital discharge paperwork, dated 5/9/24, indicated Resident #85 presented to the hospital with lethargy, anorexia (abnormal loss of appetite for food), hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and worsening wound drainage. Further review of the hospital paperwork indicated the Resident required intravenous antibiotics for sepsis during hospitalization , and was discharged back to the facility with the recommendation to change the wound vac three times per week. Review of the Wound Evaluation and Management Summary, dated 5/14/24, indicated that Resident #85 had a stage IV sacral pressure wound measuring 16.8 x 16.5 x 4.5 cm and a stage IV pressure wound on the left ischium measuring 2 x 1 x .4 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement and negative pressure wound therapy to be applied three times per week for nine days at 125 mmHg continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 5/21/24, indicated that Resident #85 had a stage IV pressure wound measuring 16.8 x 16.7 x 4.8 cm, and that the wound progress was exacerbated due to infection; the Wound Physician recommended a house supplement and sodium hypochlorite solution (dakins) twice daily for 30 days. Further review of the Wound Evaluation and Management summary indicated the Resident had a stage 4 pressure injury of the left ischium measuring 1 x 1 x 0.2 cm, and that the Wound Physician recommended alginate calcium once daily for 23 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's Nurse Practitioner progress note, dated 5/22/24, indicated that the Resident had been seen on 5/21/24 by the Wound Physician who found bone chips in the Resident's wound. Further review of the progress note indicated that the Resident was transferred to the hospital on 5/21/24 for sacral wound for IV antibiotics or hospice. Review of the hospital discharge paperwork, dated 5/24/24, indicated Resident #85 had presented to the hospital after the facility had noticed bone chips in his/her wound. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Wound Evaluation and Management Summary, dated 5/28/24, indicated that Resident #85 had a stage IV pressure wound measuring 17 x 16.8 x 4.8 cm, and that the wound continues to deteriorate; the Wound Physician recommended sodium hypochlorite solution (dakins) twice daily for 23 days. Further review of the Wound Evaluation and Management summary indicated the Resident had a stage 4 pressure injury of the left ischium measuring 1 x 0.9 x 0.2 cm, and that the Wound Physician recommended alginate calcium once daily for 23 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 6/4/24, indicated that Resident #85 had a stage IV pressure wound measuring 17 x 17 x 4.8 cm, and that the wound was exacerbated by acute osteomyelitis; the Wound Physician recommended a house supplement and sodium hypochlorite solution (dakins) twice daily for 16 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's progress note, dated 7/10/24, indicated the Resident was sent to the hospital as the resident was shaking and pale. Review of the hospital discharge paperwork, dated 7/20/24, indicated Resident #85 presented to the hospital on 7/10/24 with severe sepsis secondary to sacral wound infection requiring admission to the ICU (intensive care unit) for pressor support. Further review of the hospital discharge paperwork indicated the Resident's wound was debrided on 7/11/24, the Resident required IV antibiotics for sepsis, a urinary foley catheter was placed on 7/11, 80 days after the Wound Physician initially recommended the placement of the foley catheter, and a wound vac was placed on 7/13 with instructions to be changed on Monday, Wednesday, and Friday. Review of the most recent Wound Evaluation and Management Summary, dated 7/23/24, indicated that Resident #85 had a stage IV pressure wound measuring 16 x 15.5 x 4.8 cm, and that the wound was not at goal; the Wound Physician recommended a house supplement and to change the wound vac three times per week. Review of Resident #85's physician orders indicated the following discontinued orders: - Change (wound vac) dressing every 3 days and PRN (as needed), initiated on 4/22/24 and discontinued on 5/24/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's physician orders indicated the following active orders: - Change Negative pressure wound therapy (wound vac) dressing every 3 days and PRN, initiated 7/20/24. - Change foley catheter as needed, initiated 7/20/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's TAR indicated that foley care was initiated on 7/20/24. Further review of Resident #85's physician orders, hospital discharge orders, diet manager change history, and TAR indicated that the lotrisone cream, and house supplement recommended by the Wound Physician were never initiated, a wound treatment was not ordered until 3/23/24, 12 days after nursing had initially identified the necrotic wound, and that a foley catheter was not placed until 7/11/24, 80 days after the Wound Physician initially recommended the placement of a foley catheter. Review of Resident #85's MAR failed to indicate that the wound vac was ever changed three times a week as recommended by the Wound Physician. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/23/24, indicated that Resident #85 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 had an unhealed Stage IV pressure ulcer and was at risk for developing pressure. On 7/30/24 at 8:01 A.M., the surveyor observed the Wound Physician and the Unit Supervisor performing wound care on Resident #85. The wound was larger in diameter than a cantaloupe with a bright red wound bed and some yellow-colored tissue. During an interview on 7/29/24 at 2:52 P.M., the Nurse Supervisor said that if a Resident is noted with a change in skin condition that a skin assessment will be done, that the change would be reported to the physician, and that a treatment order would be placed. The Nurse Supervisor said that he accompanies the Wound Physician during her wound rounds on Tuesdays. The Nurse Supervisor said that it was his responsibility to print the Wound Physician recommendations and to present them to the NP and that the signed recommendations will be placed in the physical chart. The Nurse Supervisor said that he never has the time to follow this process because he is always working on a cart, as a result the Wound Physician's recommendations for treatment changes don't get implemented. Review of Resident #85's medical chart failed to indicate that the Wound Physician's recommendations for lotrisone, a house supplement, foley catheter placement, or a three day a week wound vac change were reviewed by the NP or MD. During an interview on 7/31/24 at 3:05 P.M., NP #1 said she would not disagree with the Wound Physician recommendations and that the recommendations sound reasonable, but cant recall if she was aware of them. During an interview on 7/30/24 at 7:36 A.M., the Wound Physician said her expectation was that the nurse rounding with her should print, review and implement her recommendations. The Wound physician said she was not aware that her recommendation for lotrisone was not implemented. The Wound physician said the wound vac should have been changed three times a week, she was not aware that it was ordered for two times a week and that was not the correct order. The Wound Physician said she had recommended a foley catheter but that it wasn't implemented by the facility. 44095 2. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, and protein malnutrition. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #24 required total dependence for toileting and bed mobility and he/she had functional limitations in range of motion on both sides of his/her upper and lower extremities. The MDS indicated Resident #24 had four stage 4 pressure ulcers and one unstageable ulcer. Review of Resident #24's consultant wound evaluation and summary, dated 7/2/24, indicated the following: -Site 7: Stage 4 Pressure Wound of the right ischium. Continue: Alginate calcium apply once weekly for 9 days. -Site 10: Stage 4 Pressure Wound of the left ischium. Continue: Alginate calcium apply once daily for 9 days; Skin sub application (restorigin, is a placental tissue allograft that is used as a protective barrier in wound care applications. The natural properties of amniotic tissue provide mechanical protection and growth factors to aid in the management of acute and chronic wounds) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. Foam silicone boarder apply once daily for 9 days. -Site 12: Stage 4 Pressure Wound Sacrum. Continue: Alginate calcium apply once daily for 9 days; Skin sub application (restorigin) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. Foam silicone boarder & faced apply once daily for 30 days. -Site 13: Stage 4 Pressure Wound of the left, lateral ankle. Continue: Santyl apply once daily for 23 days; Alginate calcium apply once daily for 23 days. -Site 15: Unstageable (due to necrosis) Pressure Wound of the right buttock., Continue: Alginate calcium apply once daily for 30 days; Santyl apply once daily for 30 days. Wound Size: 0.9 cm x 0.9 cm x unmeasured in centimeters (cm) Review of Resident #24's consultant wound evaluation and summary, dated 7/9/24, indicated the following: -Site 15: Unstageable (due to necrosis) Pressure Wound of the right buttock., Continue: Alginate calcium apply once daily for 30 days; Santyl apply once daily for 30 days. Wound Size: 2 cm x 6 cm x unmeasured in centimeters (cm) (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #24's consultant wound evaluation and summary, dated 7/15/24, indicated the following: -Site 15: Unstageable (due to necrosis) Pressure Wound of the right buttock., Continue: Alginate calcium apply once daily for 30 days; Santyl apply once daily for 30 days. Wound Size: 2 cm x 5.9 x unmeasured in centimeters (cm) Review of Resident #24's consultant wound evaluation and summary, dated 7/23/24, indicated the following: -Site 7: Stage 4 Pressure Wound of the right ischium. Continue: Alginate calcium apply once daily for 22 days. -Site 10: Stage 4 Pressure Wound of the left ischium. Continue: Alginate calcium apply once daily for 22 days; Skin sub application (restorigin) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. -Site 12: Stage 4 Pressure Wound Sacrum. Continue: Alginate calcium apply once daily for 16 days. -Site 13: Stage 4 Pressure Wound of the left, lateral ankle. Continue: Alginate calcium apply once daily for 9 days; Santyl apply once daily for 9 days. -Site 15: Stage 4 Pressure Wound of the right buttock. Continue: Alginate calcium apply once daily for 16 days; Santyl apply once daily for 16 days. Wound Size: 2 cm x 5.9 x unmeasured in centimeters (cm), post-debridement assessment of this previously unstageable necrotic area wound has revealed the underlying deep tissue at the at the muscle/fascia level, which had previously been obscured by necrosis prior to this point. This wound has now revealed itself to be a Stage 4 pressure ulcer. On 7/25/24, the surveyor reviewed Resident #24's active physician's orders for wound care which indicated the following orders were being implemented and documented on the Treatment Administration Record (TAR) by nursing staff during the recertification survey: - Sacral wounds, cleanse with vashe (antimicrobial wound cleanser) or (a similar antibacterial wound cleanser) pat dry, apply alginate (a dressing, highly absorbent wound care product from natural seaweed extract) and eclipse (absorbent dressing), alginate foam dressing daily and PRN, one time a day, initiated on 10/18/22. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of this treatment order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound sites 7, 10, 12, or 15. - Alginate calcium apply once daily for 30 days, foam with boarder (silicone sacrum) apply once daily for 30 days), Skin prep apply once daily 30 days, one time a day, initiated on 5/22/23. Further review of this treatment order failed to include a location. - Skin prep apply once daily for 16 days, one time a day, initiated on 5/24/23. Further review of this treatment order failed to include the location. - Skin prep apply once daily for 16 days, one time a day, initiated on 6/22/23. Further review of this treatment order failed to include the location. - Right buttock-antifungal prescription, apply twice daily for 13 days: lotrisone (prescription medication used to treat fungal skin infections) cream to bilateral buttocks and groin, two times a day, initiated on 7/10/23. Further review of this order, indicated the treatment was for 13 days and the order should have been discontinued and this order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound sites 7, 10, 12, or 15. - Right buttock-alginate calcium, apply once daily for 30 days; foam with border (silicone-sacrum) apply once daily for 30 days; one time a day, initiated on 7/10/23. Further review of this treatment order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound sites 7, 10, 12, or 15. - Santyl (a medication that helps remove dead skin tissue and aid in wound healing) External Ointment 250 units/gram (Collagenase), Apply to right buttock area topically, two times a day for wound care. Wash with normal saline pat dry, apply santyl to wound daily and PRN, initiated on 2/26/24. Further review of this physician's order indicated the frequency was documented as both daily and twice daily. Further review of this treatment order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound sites 7, 10, 12, or 15. - Left lateral ankle- cleanse with saline. Apply Medihoney (a hydrocolloidal suspension, helps removal of necrotic tissue and aids in wound healing) gel to wound, cover with bordered foam. Change 3x/week and as needed (PRN). Off -load with pillow or prevalon boots, every day shift every on Mon, Wed, Fri related to pressure ulcer of the left heel, initiated on 5/3/24. Further review of this treatment order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound site 13. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Medihoney Wound/Burn Dressing External Gel (Wound Dressings), apply to left ankle topically every day shift, on every Mon, Wed, Fri related to pressure ulcer of the left heel, initiated on 5/3/24. Further review of this treatment order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound site 13. - Sodium Hypochlorite External Solution 0.125 % (Sodium Hypochlorite, form of bleach for wound cleaning that has been diluted), apply to sacral ischial wounds topically every day and evening shift related to pressure ulcer of the sacral region, initiated on 5/3/24. Further review of this treatment order failed to correspond with the Wound Physician's recommendations, dated 7/23/24, for wound sites 7, 10, 12, or 15. During an interview on 8/1/24 at 4:17 P.M., Nurse #13 said Resident #24 has multiple wounds on his/her buttocks. Nurse #13 said he performs wound care on the evening shift to the sacral wounds and the buttocks wounds. Nurse #13 said that Resident #24's wound orders are messy and difficult to follow, and we try to do our best. Nurse #13 said he has not notified the provider about the wound care orders or the consultant wound physician's reco [TRUNCATED]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49880 Based on record review and interview, the facility failed to provide an accurate estimated cost of services to Resident's or their representatives, for two Residents (#7 and #62) out of three records reviewed, to ensure they were informed of their potential financial liabilities of the cost of items and services provided in addition to the daily per diem room rate. Findings include: The SNF ABN (CMS-10055) notice is administered to a Medicare recipient when the facility determines that the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all of the Medicare benefit days for that episode. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Review of the notices provided to three residents who came off their Medicare Part-A Benefit and, either remained at the facility or discharged home or to a lesser level of care, found that two out of two of the residents, who remained at the facility, were provided Advanced Beneficiary Notices that did not include an accurate estimated cost of services. Resident #7 received an ABN notice on 6/13/24 indicating that on 6/15/24 he/she may have to pay out of pocket for care if they did not have other insurance that may cover these costs at [The Facility]. The ABN indicated that the estimated cost at the facility is \$426.00 daily. The ABN failed to indicate the private pay rates for therapy services. Resident #62 received an ABN notice on 4/1/24 indicating that on 4/3/24 he/she may have to pay out of pocket for care if they did not have other insurance that may cover these costs at [The Facility]. The ABN indicated that the estimated cost at the facility is \$426.00 daily. The ABN failed to indicate the private pay rates for therapy services. During an interview on 7/24/24 at 10:21 A.M., the Accounts Receivable Manager said that she is not familiar with the SNF ABN form. She said that the social worker issues all notices to the residents and then gives them to her to upload into the system. During an interview on 7/24/25 at 10:23 A.M., Social Worker #1 said that he issues the ABN notices to residents who remained in the facility. During a follow up interview on 7/25/24 at 10:39 A.M., Social Worker #1 said the ABN forms should have all potential costs of services included on them. Social Worker #1 said the ABN provided to Resident #7 and Resident #62 only included the daily room rate and should have a breakdown of therapy costs as well.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observations and interviews, the facility failed to ensure resident protected health information (PHI) was secure and not visible to others on three of three nursing units. Findings include: On 7/23/24 at 6:45 A.M., the surveyor observed on the [NAME] Unit medication cart A, a computer screen with an electronic health record that was open, and the surveyor was able to read PHI. On 7/23/24 at 6:47 A.M., Nurse #2 returned to the medication cart, and she said the electronic health record should have been locked. On 7/24/24 at 7:56 A.M., surveyor observed the on the [NAME] Unit medication cart A, a computer screen with an electronic health record that was open to a resident's PHI. There was no nurse in sight. During this observation a food service employee delivered the food truck to the unit and walked past the open screen, a Certified Nursing Assistant, and a laboratory vendor walked by the computer screen potentially exposing PHI. On 7/24/24 at 7:58 A.M., Nurse #5 returned to the medication cart, and she said the computer screen should have been locked. On 7/25/24 at 11:54 A.M., the surveyor observed on the Hawthorne Unit medication cart A, a computer screen with an electronic health record that was open to a resident's PHI. During this observation two residents walked by the screen, one activities assistant walked by the screen, a family member, and two Certified Nurse Assistants, walked by the computer screen potentially exposing PHI. On 7/25/24 at 11:59 A.M., Nurse #4 returned to the medication cart, and she said the computer screen should have been locked. During an interview on 7/29/24 at 4:35 P.M., the Director of Nursing said nursing should ensure computer screens are locked to secure protected health information.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observations, interviews and record review, the facility failed to protect five residents, out of a total sample of 39 residents, from neglect. Specifically: 1a) For Resident #85, the facility failed to implement treatments and physician orders recommended by the consulting wound physician resulting in a new necrotic skin condition progressing to an unstageable wound leading to osteomyelitis (a bone infection) and sepsis (a life-threatening response to infection) requiring hospitalization and need for a fecal-diverting colostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, that allows digested food to pass out of the body through an external pouch system). 1b) For Resident #85, the facility failed to ensure that an air mattress was set at the appropriate setting to promote wound healing in the presence of a stage IV pressure wound (defined as deep wounds that may impact muscle, tendons, ligaments, and bone). 2a) For Resident #24, the facility failed to implement the physician's order for air mattress settings, in the presence of four stage four pressure ulcers and one unstageable pressure ulcer. 2b) For Resident #24, the facility failed to implement dietician recommendations for wound healing. 2c) For Resident #24, the facility failed to implement wound physician's recommendations for wound care. 3) For Resident #88, the facility failed to implement treatment recommendations from the wound consultant physician for a right third amputated toe surgical wound. 4) For Resident #3, the facility failed to implement wound physician's recommendations for wound care. 5) For Resident #103, the facility failed to implement treatment recommendations by the consultant wound practitioner for a stage IV pressure ulcer. Findings include: The Centers for Medicare and Medicaid Services defines neglect as the failure to provide goods and services necessary to avoid physical harm or mental anguish. Review of the facility policy titled Pressure Wound Prevention, revised January 2023, indicated, but was not limited to, the following: - Inspect the skin on a daily basis when performing or assisting with personal care or ADLS (activities of daily living). - Evaluate, report and document potential changes in the skin. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Review the interventions and strategies for effectiveness on an ongoing basis. Review of the facility policy titled Ulcer/skin Breakdown Clinical Protocol, created January 2023, indicated, but was not limited to, the following: - The nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; - The interdisciplinary team should collectively complete Route Cause Analysis for any newly identified in-house acquired pressure injury. - The wound care specialist/medical provider will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. 1a) Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. Review of Resident #85's Potential Skin care plan, initiated 3/8/23, indicated the Resident had potential for alteration in skin integrity, with the following interventions: - Complete skin condition checks weekly - Dietary interventions/evaluation - Follow MD (Medical Doctor/physician) orders for skin care and treatments (utilize best practice guidelines) Review of Resident #85's Norton Scale for predicting risk for pressure ulcer, dated 2/27/24, indicated the Resident scored an eight, placing the Resident in the high risk category. Review of Resident #85's Skin Only Evaluation, dated 3/6/24, indicated Resident #85 had no skin issues. Review of Resident #85's Skin Only Evaluation, dated 3/11/24, indicated Resident #85 had a new necrotic (the death of body tissue or an organ due to a lack of blood supply) wound on the left buttock, medial area, and that the wound did not have an odor. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's initial Wound Evaluation and Management Summary, dated 3/12/24, indicated the Wound Physician evaluated the Resident for a rash. The Wound Physician diagnosed Resident #85 with diaper dermatitis and recommended Lotrisone cream (an anti-fungal cream) to be applied twice daily to the affected area and prn (as needed). Review of Resident #85's Treatment Administration Records failed to indicate that the lotrisone cream was implemented. During an interview on 7/29/24 at 10:03 A.M., Nurse #17 said that when changes in skin are identified they should be reported to the NP (Nurse Practitioner)/MD. Nurse #17 said that the Wound Physician will give recommendations to the staff member accompanying her during wound rounds every Tuesday. Nurse #17 said that a Certified Nursing Assistant had initially reported the wound to her, and that the Resident had a wound on the middle of the coccyx and a wound on the left buttocks. Nurse #17 said she had not reported the wound to the physician because the wound did not need the physicians' attention because of how small it was. Nurse #17 said she did not apply lotrisone, and that the aides have been using house barrier cream which was not a new treatment for the newly identified wound in March. During a follow-up interview on 7/30/24 at 8:19 A.M., Nurse #17 said that communication with the physician would be included in a progress note, and in the communication book. Review of the communication book and Resident #85's progress notes failed to indicate that the physician was notified of the new necrotic skin condition identified on 3/11/24. Review of the Nurse practitioner (NP) progress note, dated 3/13/24, failed to indicate that the NP was aware of, evaluated, or initiated treatments for Resident #85's necrotic wound. Review of Resident #85's wound evaluation and management summary, dated 3/19/24, indicated the Wound Physician evaluated the Resident's rash. The Wound Physician recommended lotrisone cream for the diaper dermatitis. Review of Resident #85's Treatment Administration Records (TAR) failed to indicate that the lotrisone cream was implemented. Review of Resident #85's medical record failed to indicate a nursing skin evaluation was completed the week of 3/18/24. Review of Resident #85's physician orders indicated the following discontinued orders: - Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to Sacrum topically one time a day for Wound, initiated 3/23/24, 12 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 5/24/24. - Left butt wound wash with normal saline cover with silicone bordered form dressing every day shift left butt wound, initiated 3/22/24, 12 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 5/24/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Wound Consult for left butt wound, initiated 3/25/24, 15 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 4/25/24. Review Resident #85's progress note, written by NP #2, dated 3/26/24, indicated the following: I was asked to see this pt (patient) because of worsening wounds. Nursing reports they had started as superficial, but now were open and deeper. He/she had not been followed by the wound care team. Consult initiated and wound team saw this resident the AM of 3/26. They will now follow his/her wounds which are pressure related. Further review of Resident #85's progress note, written by Nurse Practitioner (NP) #2, dated 3/26/24, indicated that the consult for the Resident's wound was initiated 15 days after nursing had initially identified the necrotic area. Further review of the progress note indicated that the wound team requested multi-interventions in addition to wound care. During an interview on 7/30/24 at 11:42 A.M., NP #2 said she would expect to be notified of a new skin condition. NP #2 said that her review of systems includes communication with the nurses, and that she does not do a full-skin check as part of her regular evaluation; the NP said that she would only look at skin if a concern is brought to her attention. NP #2 said a staff member will follow the Wound Physician to communicate the recommendations to her, and that she would expect the recommendations to be implemented. NP #2 said that the risk of not implementing the Wound Physician recommendations would be that the wound could get worse, and that the wound could get infected and develop osteomyelitis. NP #2 said she was first notified of the wound on 3/26/24, when nursing reported to her that the wound had developed an odor, and that when she had evaluated the Resident on 3/13/24 she had not been aware of the wound. During an interview on 7/31/24 at 9:16 A.M., Physician #2 said he would expect nursing to notify himself or an NP of a change in skin condition. Physician #2 said a facility nurse should be following the Wound Physician for recommendations, and that the risk of Wound Physician recommendations not being followed would be that the wound would probably get worse if the Resident was not receiving treatment. Review of Resident #85's Wound Evaluation and Management Summary, dated 3/26/24, indicated Resident #85 had an unstageable (due to necrosis) pressure injury on his/her left ischium measuring 2.5 x 2.4 cm (centimeters), and an unstageable (due to necrosis) pressure injury on his/her sacrum measuring 3.9 x 3.7 cm. Further review of the wound evaluation indicated that the duration of both wounds was greater than six days, and that the Wound Physician recommended a house supplement (a calorically and nutritionally fortified drink typically utilized to address weight loss and/or meet assist in meeting nutrient, such as protein, needs) alginate calcium (a gel that promotes wound healing), and santyl (an ointment used to promote the healing of skin ulcers by removing damaged tissue). Review of the nursing progress note, dated 3/27/24, indicated Resident #85 was being transferred to emergency room for evaluation as the resident was very weak [sic]. And oxygen of at 58% at room air. Review of Resident #85's TAR failed to indicate that alginate calcium, or santyl were implemented prior to the Resident's hospitalization on [DATE]. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the hospital discharge paperwork, dated 4/22/24, indicated that Resident #85 presented to the hospital on 3/27/24 with encephalopathy (a broad term for any brain disease that alters brain function), found to be in sepsis with an infected sacral ulcer as the presumed source. Further review of the hospital paperwork indicated that the Resident underwent wound debridement (a procedure that removes unhealthy or dead tissue from a wound to promote healing and prevent infection) on 3/29/24, 3/31/24, 4/5/24, and 4/21/24, and that fecal diversion was indicated to allow for the wound to heal due to the wound's proximity to the anus; on 4/5/24 the Resident underwent a diverting loop sigmoid colostomy creation. The hospital paperwork indicated there was clinical and imaging evidence of osteomyelitis with the sacrum/coccyx bones exposed in the wound. Review of the nursing progress note, dated 4/22/24, indicated that Resident #85 had returned from the hospital with a sacral ulcer with underlying osteomyelitis status post multiple debridement's and the creation of a diverting loop colostomy. Further review of the progress note indicated that the Wound Physician would evaluate the Resident on 4/23/24 to provide guideline on wound vac (a treatment that uses suction to help wounds heal) use [sic]. Review of the Minimum Data Set (MDS) assessment, dated 4/28/24, indicated that Resident #85 scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated that Resident #85 had a new Stage IV and a new Stage III pressure ulcer and was at risk for developing pressure ulcers. According to the Mayo Clinic, complications and outcomes of Stage IV pressure ulcers include: - Osteomyelitis, which is characterized by a mixture of inflammatory cells, fibrosis, bone necrosis, and new bone formation. It is associated with nonhealing wounds, surgical flap complications, and an increased length of hospitalization . It may develop within the first 2 weeks of pressure ulcer formation and despite treatment may require amputation in lower extremity cases. - Joint infections (septic arthritis) can damage cartilage and tissue. - Bone infections (osteomyelitis) can reduce the function of joints and limbs. - Long-term, nonhealing wounds can develop into a type of squamous cell carcinoma. - Sepsis (blood infection). Review of the Wound Evaluation and Management Summary, dated 4/23/24, indicated that Resident #85 had a stage IV sacral pressure wound (Stage IV pressure wounds are defined as deep wounds that may impact muscle, tendons, ligaments, and bone) measuring 17 x 17 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement, foley catheter (a medical device that helps drain urine from the bladder) and negative pressure wound therapy (wound vac) to be applied three times per week for 30 days at 125 mmHg (millimeter of mercury, a manometric unit of pressure) continuously. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated on 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 4/30/24, indicated that Resident #85 had a stage IV sacral pressure wound measuring 17 x 16.8 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement and negative pressure wound therapy to be applied three times per week for 23 days at 125 mmHg continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated on 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's progress notes indicated the Resident was transferred to the emergency roiaognom on [DATE]. Review of the hospital discharge paperwork, dated 5/9/24, indicated Resident #85 presented to the hospital with lethargy, anorexia (abnormal loss of appetite for food), hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and worsening wound drainage. Further review of the hospital paperwork indicated the Resident required intravenous antibiotics for sepsis during hospitalization , and was discharged back to the facility with the recommendation to change the wound vac three times per week. Review of the Wound Evaluation and Management Summary, dated 5/14/24, indicated that Resident #85 had a stage IV sacral pressure wound measuring 16.8 x 16.5 x 4.5 cm and a stage IV pressure wound on the left ischium measuring 2 x 1 x .4 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement and negative pressure wound therapy to be applied three times per week for nine days at 125 mmHg continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 5/21/24, indicated that Resident #85 had a stage IV pressure wound measuring 16.8 x 16.7 x 4.8 cm, and that the wound progress was exacerbated due to infection; the Wound Physician recommended a house supplement and sodium hypochlorite solution (dakins) twice daily for 30 days. Further review of the Wound Evaluation and Management summary indicated the Resident had a stage 4 pressure injury of the left ischium measuring 1 x 1 x 0.2 cm, and that the Wound Physician recommended alginate calcium once daily for 23 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's Nurse Practitioner progress note, dated 5/22/24, indicated that the Resident had been seen on 5/21/24 by the Wound Physician who found bone chips in the Resident's wound. Further review of the progress note indicated that the Resident was transferred to the hospital on 5/21/24 for sacral wound for IV antibiotics or hospice. Review of the hospital discharge paperwork, dated 5/24/24, indicated Resident #85 had presented to the hospital after the facility had noticed bone chips in his/her wound. Review of the Wound Evaluation and Management Summary, dated 5/28/24, indicated that Resident #85 had a stage IV pressure wound measuring 17 x 16.8 x 4.8 cm, and that the wound continues to deteriorate; the Wound Physician recommended sodium hypochlorite solution (dakins) twice daily for 23 days. Further review of the Wound Evaluation and Management summary indicated the Resident had a stage 4 pressure injury of the left ischium measuring 1 x 0.9 x 0.2 cm, and that the Wound Physician recommended alginate calcium once daily for 23 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 6/4/24, indicated that Resident #85 had a stage IV pressure wound measuring 17 x 17 x 4.8 cm, and that the wound was exacerbated by acute osteomyelitis; the Wound Physician recommended a house supplement and sodium hypochlorite solution (dakins) twice daily for 16 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's progress note, dated 7/10/24, indicated the Resident was sent to the hospital as the resident was shaking and pale. Review of the hospital discharge paperwork, dated 7/20/24, indicated Resident #85 presented to the hospital on 7/10/24 with severe sepsis secondary to sacral wound infection requiring admission to the ICU (intensive care unit) for pressor support. Further review of the hospital discharge paperwork indicated the Resident's wound was debrided on 7/11/24, the Resident required IV antibiotics for sepsis, a urinary foley catheter was placed on 7/11, 80 days after the Wound Physician initially recommended the placement of the foley catheter, and a wound vac was placed on 7/13 with instructions to be changed on Monday, Wednesday, and Friday. Review of the most recent Wound Evaluation and Management Summary, dated 7/23/24, indicated that Resident #85 had a stage IV pressure wound measuring 16 x 15.5 x 4.8 cm, and that the wound was not at goal; the Wound Physician recommended a house supplement and to change the wound vac three times per week. Review of Resident #85's physician orders indicated the following discontinued orders: - Change (wound vac) dressing every 3 days and PRN (as needed), initiated on 4/22/24 and discontinued on 5/24/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's physician orders indicated the following active orders: - Change Negative pressure wound therapy (wound vac) dressing every 3 days and PRN, initiated 7/20/24. - Change foley catheter as needed, initiated 7/20/24. Review of Resident #85's TAR indicated that foley care was initiated on 7/20/24. Further review of Resident #85's physician orders, hospital discharge orders, diet manager change history, and TAR indicated that the lotrisone cream, and house supplement recommended by the Wound Physician were never initiated, a wound treatment was not ordered until 3/23/24, 12 days after nursing had initially identified the necrotic wound, and that a foley catheter was not placed until 7/11/24, 80 days after the Wound Physician initially recommended the placement of a foley catheter. Review of Resident #85's MAR failed to indicate that the wound vac was ever changed three times a week as recommended by the Wound Physician. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/23/24, indicated that Resident #85 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 had an unhealed Stage IV pressure ulcer and was at risk for developing pressure. On 7/30/24 at 8:01 A.M., the surveyor observed the Wound Physician and the Unit Supervisor performing wound care on Resident #85. The wound was larger in diameter than a cantaloupe with a bright red wound bed and some yellow-colored tissue. During an interview on 7/29/24 at 2:52 P.M., the Nurse Supervisor said that if a Resident is noted with a change in skin condition a skin assessment will be done, that the change would be reported to the physician, and that a treatment order would be placed. The Nurse Supervisor said that he accompanies the Wound Physician during her wound rounds on Tuesdays. The Nurse Supervisor said that it was his responsibility to print the Wound Physician recommendations and to present them to the NP and that the signed recommendations will be placed in the physical chart. The Nurse Supervisor said that he never has the time to print this process because he is always working on a cart, as a result the Wound Physician's recommendations for treatment changes don't get implemented. Review of Resident #85's medical chart failed to indicate that the Wound Physician's recommendations for lotrisone, a house supplement, foley catheter placement, or a three day a week wound vac change were reviewed by the NP or MD. During an interview on 7/31/24 at 3:05 P.M., NP #1 said she would not disagree with the Wound Physician recommendations and that the recommendations sound reasonable, but can't recall if she was aware of them. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/30/24 at 7:36 A.M., the Wound Physician said her expectation was that the nurse rounding with her should print, review and implement her recommendations. The Wound physician said she was not aware that her recommendation for lotrisone was not implemented. The Wound physician said the wound vac should have been changed three times a week, she was not aware that it was ordered for two times a week and that was not the correct order. The Wound Physician said she had recommended a foley catheter but that it wasn't implemented by the facility. During a follow-up interview on 7/30/24 at 11:13 A.M., the Wound Physician said that when she is consulted, she does not do a full skin check due to time constraints. The Wound Physician said she was initially consulted for Resident #85 to evaluate a rash on the frontal groin area, and nothing else; as the rash was on the front she may not have evaluated the backside and she was not aware of a necrotic wound when she evaluated the rash. The Wound Physician said this may have been a result of bad communication. During an interview on 7/31/24 at 11:46 A.M., the Director of Nursing said she would consider it neglectful to not provide services or treatments that are needed, and that she would consider it neglectful for a nurse to identify a wound but fail to notify the physician or initiate treatments. 1b) Review of the facility policy, titled Supportive surfaces - air mattress, indicated, but was not limited to, the following: Low air mattress use is indicated as follows: - To assist in the treatment and/or prevention of pressure ulcers as part of the holistic program of pressure ulcer management - As part of a pain management program when indicated for resident comfort Settings: - The patient weight indication is a close approximation of the correct setting. If the mattress is too soft or firm, simply press the up or down arrows to adjust, as necessary. - It may be necessary to alter weight setting to get optimal comfort setting for patients. If patient feels that the bed is too firm/soft, lower or increase weight setting one increment at a time and wait for stabilization before evaluating. Review of Resident #85's physician orders indicated the following active order: - Air Mattress to be for pressure relief. Set to manufacturers recommendations check functionality every shift Review of Resident #85's most recent weight reading, dated 7/20.24, indicated the Resident weighed 141 lbs. On 7/23/24 at 9:15 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. (pounds). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/25/24 at 9:42 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. On 7/25/24 at 12:01 P.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. On 7/26/24 at 7:56 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. On 7/29/24 at 10:32 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. During an observation and interview on 7/31/24 at 3:17 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. Resident #85 said his/her bed was not comfortable, and that it was too firm. During an observation and interview on 7/31/24 at 3:22 P.M., Nurse #8 said the air mattress should be set to Resident #85's weight, and that the risk of an air mattress being too firm is that it would delay wound healing. The surveyor and Nurse #8 observed Resident #85 in bed, his/her air mattress was set to 9. Nurse #8 said the air mattress should not be set to nine because the Resident did not weight 350 lbs., and that the air mattress was too firm. 44095 2. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, and protein malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #24 required total dependence for toileting and bed mobility and he/she had functional limitations in range of motion on both sides of his/her upper and lower extremities. The MDS indicated Resident #24 had four stage 4 pressure ulcers and one unstageable ulcer. Review of Resident #24's ADV - LN: Norton Scale for Predicting Risk of Pressure Ulcer, dated 1/30/24, 5/24/24, and 7/23/24, indicated Resident #24 was at high risk for skin breakdown as evidenced by a score of 5. Review of Resident #24's ADV - LN: Norton Scale for Predicting Risk of Pressure Ulcer, dated 4/26/24, indicated Resident #24 was at high risk for skin breakdown as evidenced by a score of 7. 2a. On 7/23/24 at 8:10 A.M., 7/23/24 at 9:55 A.M., 7/23/24 at 12:10 P.M., 7/23/24 at 3:21 P.M., 7/24/24 3:05 A.M., 7/24/24 at 7:23 A.M., 7/24/24 at 10:03 A.M., 7/25/24 at 6:42 A.M., 7/25/24 at 8:34 A.M., 7/25/24 at 11:54 A.M., 7/25/24 at 12:50 P.M., 7/25/24 at 4:06 P.M., 7/26/24 at 6:50 A.M., 7/26/24 at 12:31 P.M., and on 7/29/24 at 6:56 A.M., the surveyor observed Resident #24 in his/her bed on an air mattress set to 325. Review of the Resident #24's most recent weights in the electronic medical record indicated the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 5/3/24 - 167.0 pounds (lbs) - 7/25/24 - 161.2 lbs Review of Resident #24's physician's order, dated 11/8/22, indicated: - Low Air Mattress - setting 250. Check setting and function every shift. Review of Resident #24's plan of care related to actual skin breakdown, dated as revised 5/9/24, indicated: - Low Loss Air Mattress in place. Check for proper function and ensure proper setting, every shift and as needed. Review of Resident #24's Treatment Administration Record (TAR), dated July 2024, indicated nursing implemented air mattresses setting (set to 250) as ordered on 7/23/24, 7/24/24, 7/25/24, 7/26/24, and 7/29/24. However, based on observations of Resident #24's air mattress was not set to the correct setting. During an interview on 7/29/24 at 7:08 A.M., Certified Nurse Assistant (CNA) #1 said CNAs do not adjust air mattress settings and she said Resident #24 has skin wounds. During an interview on 7/29/24 at 7:10 A.M., Nurse #11 (who had just completed her overnight shift 11:00 P. M., to 7: 00A.M.) said Resident #24 has multiple wounds and he/she uses an air mattress for wound healing. Nurse #11 said air mattress settings are set according to physician's order based on the Resident's weight and CNAs do not adjust air mattress settings. Nurse #11 said she is supposed to verify physician's orders every shift and the orders are documented on the TAR. 2b. Review of Resident #24's dietitian's note, dated 6/30/24, indicated: - Suggest Vitamin C 500 mg twice daily, Zinc 220 mg x 30 days, MVI (multivitamin) with minerals for wound healing. Discussed with nursing. Further Review of Resident #24's medical record failed to include documentation to support nursing implemented the dietitian's recommendations. Review of Resident #24's risk meeting note, dated 7/8/24, indicated: - Resident reviewed by interdisciplinary team (IDT) at Risk meeting. Resident bedbound by preference/discomfort, wounds, weights. During an interview on 7/30/24 at 1:50 P.M., the Dietician said her recommendations for weekly weights, vitamin C and zinc 220 were not implemented by nursing but should have been. 2c. Review of Resident #24's consultant wound evaluation and summary, dated 7/2/24, indicated the following: -Site 7: Stage 4 Pressure Wound of the right ischium. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Continue: Alginate calcium apply once weekly for 9 days. -Site 10: Stage 4 Pressure Wound of the left ischium. Continue: Alginate calcium apply once daily for 9 days; Skin sub application (restorigin, is a placental tissue allograft that is used as a protective barrier in wound care applications. The natural properties of amniotic tissue provide mechanical protection and growth factors to aid in the management of acute and chronic wounds) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. Foam silicone boarder apply once daily for 9 days. -Site 12: Stage 4 Pressure Wound Sacrum. Continue: Alginate calcium apply once daily for 9 days; Skin sub application (restorigin) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations[TRUNCATED]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 45763 Based on observations, interviews and record review, the facility failed to identify and assess the use of pillows tucked underneath a fitted sheet on both sides of the bed as a potential restraint for one Resident (#105) out of a total sample of 39 residents. Findings include: Review of the facility policy, titled Restraint Use, revised January 2023, indicated, but was not limited to, the following: - Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. - Convenience is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. - All residents have the right to be free from any form of physical or chemical restraint, imposed by staff as a means of coercion, discipline, convenience or retaliation and not required to treat the resident's medical symptoms. - Restraints may not be used for staff convenience. - Use of restraint must be implemented in accordance with safe and appropriate restraint techniques as determined by the facility policy and in accordance with state law. - A licensed independent practitioner must give an order for the use of restraints. - Orders for restraint should specify: a. The reason (medical necessity; rationale for the use of restraint) for the restraint. b. The type of restraint. c. The extremity or body part(s) to be restrained: - The use of restraint shall be documented in the treatment plan. The treatment plan shall be reviewed and revised every 90 days. - All restraints are to be kept in full view and not covered with sheet or bedspread. - Assessment of the resident in restraints, including assessment intervals, shall be based on the individual resident's needs, the resident's condition and the type of restraint used. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assessment of the resident during restraint check shall include (As applicable): a. The physical and emotional well-being of the resident b. That the resident's rights, dignity, and safety are maintained. c. If less restrictive methods may be used. d. Identification of specific behavioral changes that would indicate that restraint is no longer necessary. e. Respiratory status f. Circulatory status g. The mental status and cognitive function of the resident h. Level of distress and agitation of the resident, i.e., restless, resting, agitated, talking in normal tone of voice, yelling. i. Assess for skin breakdown. j. Personal hygiene k. Nutrition, presence/absence of hunger and thirst. l. Toileting m. Vital signs n. Any injuries caused by the application of the restraint. o. Whether the restraint has been applied and removed correctly. - Documentation in the medical record should include: - Restraint orders, including the rationale for the restraint, the type of restraint, the extremity or body part(s) to be restrained - Assessment and reassessments of the resident - Condition/behavior required of the resident for the release of restraints. - The discussion with the resident/family regarding the need for restraints. Resident #105 was admitted to the facility in May 2024 with diagnoses including stroke. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #105's most recent Minimum Data Set (MDS) assessment, dated 6/5/24, indicated that the Resident scored a 4 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that restraints were not used for Resident #105. On 7/23/24 at 9:54 A.M., the surveyor observed Resident #105 lying in bed, there were pillows tucked under the Resident's bed sheets on both sides of the resident creating barrier. On 7/25/24 at 9:39 A.M., the surveyor observed Resident #105 lying in bed, there were pillows tucked under the Resident's bed sheets on both sides of the resident creating barrier. Review of Resident #105's medical record failed to indicate that a restraint assessment was ever completed, or that a consent or physician's order for a restraint were ever obtained. During an observation and interview on 7/29/24 at 7:45 A.M., the surveyor observed Resident #105 lying in bed, there were pillows tucked under the Resident's bed sheets on both sides of the resident creating barrier. Certified Nursing Assistant (CNA) #1 said that they place the pillows there at nighttime because the Resident tries to get out of bed and that the pillows are there to keep the Resident in bed. During an interview on 7/29/24 at 7:47 A.M., Nurse #15 said that restraints aren't used in the facility, but that a restraint would need a physician order, consent, assessment, and care plan. Nurse #15 said that the pillows were a potential for restraint, and that the CNA's should not be placing the pillows there for that for that reason. During an interview on 8:17 A.M., the Director of Nursing (DON) said that they don't have any restraints in the facility, but that a restraint would require a restraint assessment. The DON said that the pillows tucked under Resident #105's sheets on both sides of the Resident would be considered a restraint.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45763 Based on record review and interviews, the facility failed to implement their abuse prohibition policy for one Resident (#81) out of a total sample of 39 residents. Specifically, for Resident #81, the facility failed to ensure facility staff immediately reported an allegation of physical abuse to the Director of Nursing or Administrator, as required. Findings include: Review of the facility policy, titled Abuse, revised October 2022, indicated, but was not limited to the following: - The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. - Physical abuse includes hitting, slapping, punching, and kicking - Instruct staff, resident/patient, family, visitor, etc. to report immediately, without fear of reprisal, any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property. - All alleged violations involving abuse, neglect, exploitation, and/or misappropriation of resident property will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law. - Staff should notify the shift supervisor/charge nurse/ manager immediately if suspected abuse, neglect, mistreatment, or misappropriation of property occurs. - Once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator/Director immediately and initiate gathering requested information. An investigation MUST be directed by the Administrator or designee immediately. Resident #81 was admitted to the facility in June 2023 with a diagnosis of depression. Review of the Minimum Data Set (MDS) assessment, dated 5/30/24, indicated that Resident #81 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. On 7/26/24 at 8:17 A.M., the surveyor observed Resident #81 tell Certified Nursing Aide (CNA) #12 that someone had hit him/her with a cricket bat last week while he/she was in bed. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/24 at 11:43 A.M., the Administrator said that staff should immediately communicate any allegations of abuse to the supervisor who would then report the allegation to either himself or the Director of Nursing (DON). The Administrator said that no allegations of abuse had been reported to him today. During an interview on 7/26/24 at 11:47 A.M., the DON said no allegations of abuse had been reported to her today, and that she would expect staff to have reported Resident #81's report of being hit by a cricket bat to her. During an interview on 7/26/24 at 12:05 P.M., CNA #12 said that she had approached Resident #81 because the Resident looked scared, and that the Resident had said to her that they whack me. CNA #12 said she had not told anybody about Resident #81's allegation of abuse because she thought the Resident was confused.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on record review and interviews, the facility failed to thoroughly investigate an injury of unknown origin (a fracture), for one Resident (#3) out of a total sample of 39 residents. Findings include: Review of the policy titled, Abuse, dated as revised 10/23/22, the facility prohibits the mistreatment, neglect and abuse of residents/patients: - The facility will thoroughly investigate, under the direction of the Administrator, all injuries of unknown source to determine if abuse or neglect was involved. - An injury will be classified as an Injury of Unknown Source when both of the following conditions are met. - The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident. - The injury is suspicious because of the extent of the injury. - Facility will initiate the investigative process. The investigation should be thorough with witness statements from staff, residents, visitors and family members who may be interview able and have information regarding the allegation. Resident #3 was admitted to the facility in September 2023 with diagnoses including stroke, acute inflammatory demyelination polyneuropathy (an autoimmune disorder characterized by the rapid onset of weakness and sensory loss), and anemia. Review of the Minimum Data Set (MDS) assessment, dated 7/4/24, indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 which indicated intact cognition. Further review of the MDS indicated Resident #3 required total assistance with activities of daily living. Review of plan of care, dated 5/6/24, indicated Resident #3 is dependent for transfers. Review of the physician progress note, dated, 5/9/24, indicated that Resident #3 went out to a dental appointment on 5/9/24. Review of nurse progress note dated, 5/10/24, Resident #3 complained of right leg ankle pain that had started on 5/9/24 and a portable x-ray on 5/10/24 indicated there was no fracture. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician progress note, dated, 5/15/24, indicated that the portable X-ray could have missed a fracture, and that Resident #3 could benefit from imaging at the emergency room . Resident #3 was sent to the emergency room for right ankle pain and a Computed Tomography (CT) scan (a medical imaging technique that uses x-rays to create detailed pictures of the inside of the body). Resident #3 was found to have a closed fracture of the right ankle. Review of the incident report dated 5/16/24, indicated: - Investigation was unable to identify the cause of fracture. Resident does not endorse any unknown injury and staff is not aware of injury. Bed/chairbound at baseline and had not had any falls. Further review of the investigation file indicated that there was no documentation to support that direct care staff were interviewed or statements were obtained from those staff members who provided direct care to Resident #3. During an interview on 7/31/24 at 3:37 P.M., Nurse #18 said when Resident #3 returned from emergency roiaognom on [DATE] with diagnoses of right ankle fracture he was not sure of the cause of the fracture or aware of any event that could have resulted in the fracture. During an interview on 7/25/24 at 4:12 P.M., Assistant Director of Nursing (ADON) said she only has progress notes for investigation as it gives timeline for when resident started complaining of pain and order of events regarding x-rays obtained. The ADON said that there were no staff interviewed to determine how resident was transferred on day of incident. The ADON said resident is a mechanical lift transfer. She said she would look to see if there was any further information to add to the investigation. During an interview on 7/31/24 at 4:17 P.M., the Director of Nurses (DON) said she completed the investigation into Resident #3's fracture. The DON said she did not obtain written statements from staff and that there was no further information to add to the investigation file. The DON said that Resident #3's fracture was unknown, and she said she did not have sufficient documentation to support she completed a thorough investigation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 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** 48990 Based on record review and staff interviews, the facility failed to provide written transfer/discharge notification for two Residents (#52 and #88) out of 39 total sampled residents when transferred to the hospital. Specifically: 1.) For Resident #52, the facility failed to provide written transfer/discharge notification when emergently discharged to the hospital. 2.) For Resident #88, the facility failed to provide written transfer/discharge notification when emergently discharged to the hospital on three separate occasions. Review of the facility policy titled Discharge/Transfer Process, revised 10/2022, indicated: - For transfers to the hospital, the nurse will ensure the appropriate details of the hospital transfer are documented in the resident's medical record. 1.) Resident #52 was admitted to the facility in September 2017 with diagnoses including quadriplegia and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #52 was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. Review of Resident #52's nursing progress note, dated 6/9/24, indicated: - Resident was sent to the hospital for nutritional management. Review of Resident #52's nursing progress note, dated 6/10/24, indicated: - The patient returned from hospital. Review of Resident #52's entire medical record failed to indicate a transfer/discharge notice was provided to the Resident or Resident Representative for emergent hospital discharge on 6/9/24. During an interview on 7/25/24 at 9:31 A.M., Nurse #2 said nurses do not provide the Residents and/or Resident Representatives with transfer/discharge notification when transferred to the hospital. During an interview on 7/25/24 at 10:40 A.M., the Social Worker said a discharge/transfer notice should be provided to the Resident or Resident Representative as soon as practicable in the case of an emergent hospital discharge. The Social Worker said nurses are responsible for providing the Resident with transfer/discharge notices when residents are transferred to the hospital unless their health care proxy is activated, and in that case the Social Worker would follow up. On 7/26/24 at 11:20 A.M., the Social Worker gave the surveyor a memo indicating: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	- Regarding Resident #52's transfer to the hospital on 6/9/14 [sic], we cannot locate documentation that Transfer and Bed-hold notices were issued. During an interview on 7/29/24 at 8:36 A.M., the Director of Nursing (DON) said a transfer/discharge notice should have been given to the Resident or Resident Representative as soon as practicable in the case of an emergent hospital discharge. 2.) Resident #88 was admitted to the facility in August 2023 with diagnoses including diabetes and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/30/24, indicated that Resident #88 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. 2a.) Review of Resident #88's nursing progress note, dated 1/16/24, indicated: - Pt. (patient) in Hospital admitted for infection. Review of census tab indicated Resident #88 was discharged to the hospital 1/16/24 and readmitted to the facility 1/25/24. Review of Resident #88's entire medical record failed to indicate a transfer/discharge notice was given to the Resident or Resident Representative for emergent hospital discharge on 1/16/24. 2b.) Review of census tab indicated Resident #88 was discharged to the hospital 4/8/24 and readmitted to the facility on [DATE]. Review of Resident #88's entire medical record failed to indicate a transfer/discharge notice was given to the Resident or Resident Representative for emergent hospital discharge on 4/8/24. 2c.) Review of Resident #88's nursing progress note, dated 5/6/24, indicated: - Patient sent to Hospital by order for bilateral feet Diabetic [sic] ulcer evaluation. Review of Resident #88's Clinical Admission Assessment, dated 5/22/24, indicated Resident #88 was readmitted to the facility from the hospital. Review of Resident #88's entire medical record failed to indicate a transfer/discharge notice was given to the Resident or Resident Representative for emergent hospital discharge on 5/6/24. During an interview on 7/25/24 at 9:31 A.M., Nurse #2 said nurses do not provide the Residents and/or Resident Representatives with transfer/discharge notification when transferred to the hospital. During an interview on 7/25/24 at 10:40 A.M., the Social Worker said a discharge/transfer notice should be provided to the Resident or Resident Representative as soon as practicable in the case of an emergent hospital discharge. The Social Worker said nurses are responsible for providing the Resident with transfer/discharge notices when residents are transferred to the hospital unless their health care proxy is activated, and in that case the Social Worker would follow up. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 7/26/24 at 11:20 A.M., the Social Worker gave the surveyor a memo indicating: - Regarding Resident #88's transfers on 1-16-24, 4-8-24, 5-6-24, we cannot locate documentation that Transfer and Bed-hold notices were issued. During an interview on 7/29/24 at 8:36 A.M., the Director of Nursing (DON) said a transfer/discharge notice should have been given to the Resident or Resident Representative as soon as practicable in the case of an emergent hospital discharge.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 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** 48990 Based on record review and interview the facility failed to provide bed hold policy notices upon transfer to the hospital for three Residents (#52, #88, and #83) out of a total sample of 39 residents. Specifically: 1.) For Resident #52, the facility failed to provide written notice of the facility's bed-hold policy when emergently discharged to the hospital. 2.) For Resident #88, the facility failed to provide written notice of the facility's bed-hold policy when emergently discharged to the hospital on three separate occasions. 3.) For Resident #83, the facility failed to provide written notice of the facility's bed-hold policy when emergently discharged to the hospital. Findings Include: Review of facility policy titled Bed Hold, dated as revised 10/2022, indicated the following: - Policy: It is the policy of this facility to provide the resident, responsible party or legal representative with notice of the facility's bed-hold policy upon admission and at the time of transfer or therapeutic leave from the facility to ensure continuity of care and residence post therapeutic leave or hospitalization . 1. This policy applies to all residents in the facility, regardless of payor source, and is in accordance with non-discrimination laws. It is in accordance with applicable Federal and State regulation. 2. Prior to transfer, therapeutic leave or acute transfer (or as soon as practicable), the facility will provide the resident and/or their representative with a written notice that includes: -a. The duration of the State bed hold policy (Medicaid Residents), if any, which the resident is permitted to return to the facility to their bed and room if applicable. -c. Facility policy regarding bed-hold periods permitting resident to return. 1.) Resident #52 was admitted to the facility in September 2017 with diagnoses including quadriplegia (paralysis of all limbs) and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #52 was rarely/never understood and a staff assessment for Brief Interview for Mental Status (BIMS) indicated severe cognitive impairment. Review of Resident #52's nursing progress note, dated 6/9/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	- Resident was sent to the hospital for nutritional management. Review of Resident #52's nursing progress note, dated 6/10/24, indicated: - The patient returned from hospital. Review of Resident #52's entire medical record failed to indicate a notice of the facility's bed-hold policy was provided to the Resident or Resident Representative for emergent hospital discharge on 6/9/24. During an interview on 7/25/24 at 9:31 A.M., Nurse #2 said nurses do not provide the Residents and/or Resident Representatives with notice of the facility's bed-hold policy when transferred to the hospital. During an interview on 7/25/24 at 10:40 A.M., the Social Worker said notice of the facility's bed-hold policy should be provided to the Resident or Resident Representative as soon as practicable in the case of an emergent hospital discharge. The Social Worker said nurses are responsible for providing the Resident with notice of the facility's bed-hold policy when residents are transferred to the hospital unless their health care proxy is activated, and in that case the Social Worker would follow up. On 7/26/24 at 11:20 A.M., the Social Worker gave the surveyor a memo indicating: - Regarding Resident #52's transfer to the hospital on 6/9/14 [sic], we can not locate documentation that Transfer and Bed-hold notices were issued. During an interview on 7/29/24 at 8:36 A.M., the Director of Nursing (DON) said notice of the facility's bed-hold policy should have been given to the Resident or Resident Representative as soon as practicable in case of emergent hospital discharge. 2.) Resident #88 was admitted to the facility in August 2023 with diagnoses including diabetes and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/30/24, indicated that Resident #88 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. 2a.) Review of Resident #88's nursing progress note, dated 1/16/24, indicated: - Pt. (patient) in Hospital admitted for infection. Review of census tab indicated Resident #88 was discharged to the hospital 1/16/24 and readmitted to the facility 1/25/24. Review of Resident #88's entire medical record failed to indicate notice of the facility's bed-hold policy was given to the Resident or Resident Representative for emergent hospital discharge on 1/16/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	2b.) Review of census tab indicated Resident #88 was discharged to the hospital 4/8/24 and readmitted to the facility on [DATE]. Review of Resident #88's entire medical record failed to indicate notice of the facility's bed-hold policy was given to the Resident or Resident Representative for emergent hospital discharge on 4/8/24. 2c.) Review of Resident #88's nursing progress note, dated 5/6/24, indicated: - Patient sent to Hospital by order for bilateral feet Diabsetic [sic] ulcer evaluation. Review of Resident #88's Clinical Admission Assessment, dated 5/22/24, indicated Resident #88 was readmitted to the facility from the hospital. Review of Resident #88's entire medical record failed to indicate notice of the facility's bed-hold policy was given to the Resident or Resident Representative for emergent hospital discharge on 5/6/24. During an interview on 7/25/24 at 9:31 A.M., Nurse #2 said nurses do not provide the Residents and/or Resident Representatives with notice of the facility's bed-hold policy when transferred to the hospital. During an interview on 7/25/24 at 10:40 A.M., the Social Worker said notice of the facility's bed-hold policy should be provided to the Resident or Resident Representative as soon as practicable in the case of an emergent hospital discharge. The Social Worker said nurses are responsible for providing the Resident with notice of the facility's bed-hold policy when residents are transferred to the hospital unless their health care proxy is activated, and in that case the Social Worker would follow up. On 7/26/24 at 11:20 A.M., the Social Worker gave the surveyor a memo indicating: - Regarding Resident #88's transfers on 1-16-24, 4-8-24, 5-6-24, we can not locate documentation that Transfer and Bed-hold notices were issued. During an interview on 7/29/24 at 8:36 A.M., the Director of Nursing (DON) said notice of the facility's bed-hold policy should have been given to the Resident or Resident Representative as soon as practicable in case of emergent hospital discharge. 49880 3. Resident #83 was admitted to the facility in April 2024 with diagnoses that include alcohol abuse, post-traumatic stress disorder (PTSD) and type 2 diabetes. Review of Resident #83's most recent Minimum Data Set (MDS) Assessment, dated 7/4/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating that the Resident is cognitively intact. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Resident #83's clinical record indicated that he/she was transferred to the hospital on 5/24/24 and 7/6/24. Additional review of the clinical record failed to indicate the facility provided Resident #83 with a bed hold notice for either transfer, as required. During an interview on 7/25/24 at 9:31 A.M., Nurse #2 said that when a resident is sent out to the hospital the nurse sends a face sheet, medication orders and a summary of why he/she is being sent to the hospital. She said that nursing does not send a bed hold policy with the resident. During an interview on 7/25/24 at 10:40 A.M., Social Worker #1 said nursing staff should issue the bed hold notice when a resident is transferred to the hospital, and it should be documented in the clinical record. He said that the center may need to provide more education about bed hold notices to staff. During an interview on 7/26/24 at 10:50 A.M., the Director of Nurses (DON) said that as a facility they may need to look at their process, but the bed hold notice should go with the resident to the hospital.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observation, interview and record review, the facility failed to accurately code in the Minimum Data Set (MDS) for four Residents (#88, #58, #92, and #3) of 39 total sampled residents. Specifically: 1.) For Resident #88, the use of restraints was inaccurately coded in the MDS. 2.) For Resident #58, the use of oxygen was inaccurately coded in the MDS. 3.) For Resident #92, the use of non-invasive mechanical ventilation was inaccurately coded on the MDS. 4.) For Resident #3, the development of a fracture was inaccurately coded in the MDS. Findings include: 1.) Review of the facility policy titled Restraints, revised 1/2023, indicated: - If two (2) bedrails are raised, the resident is able to get out of bed; this is not a restraint. Resident #88 was admitted to the facility in August 2023 with diagnoses including diabetes and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/30/24, indicated Resident #88 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS indicated Resident #88 usually required supervision or touching assistance to transfer from a bed to a chair. This MDS also indicated Resident #88 had been restrained in bed by a bed rail daily. Review of Resident #88's medical record indicated: - Quarterly MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Discharge MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Discharge MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Quarterly MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Discharge MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Discharge MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Quarterly MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	- Discharge MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. - Admission MDS, dated [DATE], indicated a bed rail was used as a physical restraint daily. Review of Resident #88's physician's orders failed to indicate an order for restraints in the past year. Review of Resident #88's entire medical record failed to indicate the use of restraints in the past year. On 7/24/24 at 7:23 A.M., the surveyor observed Resident #88 in bed with his/her eyes closed. There were no side rails on the bed. During an interview on 7/26/24 at 8:28 A.M., Resident #88 said he/she had never been restrained in bed. During an interview on 7/26/24 at 8:30 A.M., Nurse #14 said Resident #88 had never been restrained in bed. During an interview on 7/24/24 at 9:06 A.M., the MDS Nurse said Resident #88 had never required restraints. The MDS Nurse said restraints had been coded in error on the above listed MDS assessments. During an interview on 7/25/24 at 7:24 A.M., the Director of Nurses (DON) said MDS assessments should be coded according to the RAI manual. The DON said Resident #88 was never restrained and the MDS's were coded in error. 2.) Resident #58 was admitted to the facility in October 2023 with diagnoses including asthma and obstructive sleep apnea. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #58 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #58 did not receive oxygen therapy in the past 14 days. Review of vital sign trends indicated Resident #58 received oxygen on 6/21/24, 6/22/24, 6/25/24, and 7/4/24. During an interview on 7/24/24 at 10:18 A.M., Nurse #14 said Resident #58 had received oxygen for at least a month, if not longer. During an interview on 7/25/24 at 7:14 A.M., the MDS nurse said if a resident received oxygen during the 14-day look back period it should be coded on the MDS, even if there is not an order. The MDS nurse reviewed Resident #58's record and said that the MDS was coded in error because he/she did receive oxygen during that timeframe. During an interview on 7/25/24 at 7:24 A.M., the Director of Nurses (DON) said MDS's should be coded according to the RAI manual. The DON said if Resident #58 received oxygen during the time frame of the MDS look back range it should be coded on the MDS, even if there was not an order for it. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	49880 3. Resident #92 was admitted to the facility in July 2023 with diagnoses that include obstructive sleep apnea and anxiety. Review of Resident #92's most recent Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS failed to indicate the use of non-invasive mechanical ventilation, which would include the use of a Continuous Positive Airway Pressure (CPAP) machine. On 7/23/24 at 9:14 A.M., the surveyor observed a Continuous Positive Airway Pressure (CPAP) machine with tubing and mask attached hanging next to Resident #92's bed. Resident #92 said he/she applies and removes the CPAP him/herself and uses it every night. Review of Resident #92's active physician's orders failed to indicate an order for the use of CPAP. Review of Resident #92's active care plan failed to indicate a plan of care for the use of CPAP or the management of obstructive sleep apnea. During an interview on 7/25/24 at 7:23 A.M., Nurse #12 said that he works overnight and takes care of Resident #92. Nurse #12 said that the Resident uses CPAP and usually manages it him/herself. During an interview on 7/25/24 at 11:02 A.M., the Director of Nurses said there should be a physicians in place for the use of CPAP at night and it should be coded accurately on the MDS as per the RAI manual. During an interview on 7/29/24 at 7:57 A.M., The MDS Nurse said that if a resident uses CPAP at night, it should be coded on the MDS. The MDS Nurse said she did not know Resident #92 used CPAP because there was no order for use, and she never noticed it in his/her room. The MDS Nurse said the MDS was coded incorrectly. 50338 4. Resident #3 was admitted to the facility in September 2023 with diagnoses including stroke, acute inflammatory demyelinating polyneuropathy (an autoimmune disorder characterized by weakness and sensory loss in the limbs), and anemia. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #3 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 and required total assistance with all activities of daily living. Further review of MDS failed to indicate a diagnosis of a fracture. Review of nursing progress note, dated 5/15/24, indicated CT (computed tomography) scan at emergency room revealed closed fracture to the right ankle. Review of physician's orders, dated 5/21/24, indicated no weight bearing or transfers to right low extremity every shift due to right ankle fracture. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of plan of care, dated 5/23/24, indicated alteration in musculoskeletal status related to fracture of right ankle. Review of nursing progress, dated 6/18/24, indicated X-ray findings at orthopedic appointment revealed stable non- displaced tibial fracture. During an interview on 7/31/24 at 10:30 A.M., The MDS nurse reviewed Resident #3's diagnoses and MDS completed on 7/4/24 and said that the right ankle fracture was not coded on the MDS, but it should have been. During an interview on 7/31/24 at 11:56 A.M., The Director of Nursing (DON) said MDS assessments should be coded according to Resident Assessment Instrument (RAI) manual.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45763 Based on record review and interviews the facility failed to develop a baseline plan of care that included instructions needed to provide effective and person-center care for one Resident out of a total sample of 39 residents. Specifically, for Resident #27, who was assessed upon admission by nursing as a fall risk, the facility failed to develop and implement a plan of care related to falls and Resident #27 subsequently experienced a fall, 4 days after he/she admitted to the facility. Findings Include: Review of the facility policy, titled Care Plans - Baseline, revised October 2022, indicated, but was not limited to, the following: - A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Resident #27 was admitted to the facility in March 2024 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #27 was dependent on staff for transferring and walking. Review of Resident #27's clinical admission note, dated 3/28/24, indicated the following: Safety concerns - note: fall risk unsteady gait dementia causing self-ambulation. Review of a nurse progress note, dated 3/28/24, indicated Resident #27 had a shuffling gate while ambulating, and that the resident was confused. Review of a nurse progress note, dated 4/1/24, indicated Resident #27 had fallen. Review of the fall incident report, dated 4/1/24, indicated that the Resident had fallen next to the nurse's station and sustained an abrasion to his/her right upper forehead and right knee. Review of Resident #27's care plans indicated that a falls care plan was initiated on 4/10/24, 13 days after he/she had been admitted to the facility. During an interview on 8/1/24 at 12:46 P.M., CNA #1 said that Resident #27 was at risk of falling as the Resident was always trying to get up. During an interview on 8/1/24 at 1:30 P.M., the Director of Nursing said a baseline care plan for falls should have been developed on admission for Resident #27.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45763 Based on observations, record reviews and interviews the facility failed to develop and implement a person-centered comprehensive care plan for three Residents (#76 #106 and #92) out of a total sample of 39 residents. Specifically, 1. For Resident #76, the facility failed to develop a person-centered care plan for a behavior of wandering. 2. For Resident #106, the facility failed to develop a person-centered care plan for obstructive sleep apnea and the use of a continuous positive air pressure (CPAP) machine. 3. For Resident #92 the facility failed to develop a person-centered care plan for obstructive sleep apnea and the use of a continuous positive air pressure (CPAP) machine. Findings Include: Review of facility policy titled Care Plan- Comprehensive, dated as revised 10/22/22, indicated the following: Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Procedure: 6. The comprehensive, person- centered care plan will: -a. Include measurable objectives and timeframes. -b. describe the services that are being furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well- being. -f. Incorporate identified problem areas; -g. Incorporate risk factors associated with identified problems. - Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. - The comprehensive, person- centered care plan should be developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 1. Resident #76 was admitted to the facility in June 2024 with a diagnosis of dementia. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 6/12/24, indicated that Resident #76 scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of the physician note, dated 7/1/24, indicated that Resident #76 would not be safe at home as he/she tends to wander due to dementia. Review of the physician note, dated 7/8/24, indicated Resident #76 had a behavior of taking off his/her oxygen and wandering in the hallway. Review of the physician note, dated 7/12/24, indicated Resident #76 was being evaluated for insomnia and agitation/wandering. Further review of the physician note indicated the Resident continued to wander and attempt to leave the facility. Review of Resident #76's care plans failed to indicate that a care plan for wandering had been developed. During an interview on 7/23/24 at approximately 8:40 A.M., during screening a Resident in a private room said that Resident #76 had wandered into his/her room last night. On 7/25/24 at 11:24 A.M., the surveyor observed Resident #76 wandering in the hallway, the Resident said I need to go downstairs and outside to see where everyone went. I need to go downstairs, the person I'm looking for isn't here. The surveyor then observed Resident #76 go into another Resident's room. On 7/25/24 at 11:42 A.M., the surveyor observed Resident #76 wandering in the hallway, the Resident said, I'm supposed to meet someone downstairs. During an interview on 7/29/24 at 3:59 P.M., Certified Nursing Aide (CNA) #10 said Resident #76 always wanders and always wants to leave the unit and that when the Resident gets confused, he/she starts looking in other residents' rooms. During an interview on 7/29/24 at 3:52 P.M., Nurse #15 said that if a resident develops a new behavior, such as wandering, that a care plan should be developed within 24 hours. During an interview on 7/29/24 at 4:13 P.M., the Director of Nursing said that if a resident develops a new behavior, such as wandering, that a care plan should be developed right away. The DON said she was aware of Resident #76's wandering behavior but had not put a care plan in place. 48990 2. Review of the facility policy titled Respiratory - PAP Equipment, dated 1/2023, indicated, but was not limited to: - If a patient is admitted to the facility with existing equipment, the nurse should contact RT (respiratory therapist) for instruction. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Patient should be allowed to use their own equipment. Facility should obtain all necessary paperwork and instructions to manage. - Patients with Obstructive Sleep Apnea use CPAP/BIPAP (continuous positive air pressure/bilevel positive air pressure) to force air through their obstructed upper airways. While they sleep, their throat closes in and prevents air from getting into their lungs. While using the CPAP/BIPAP machine, the positive pressure prevents the airway from collapsing and the patient is able to breathe properly. Resident #106 was admitted to the facility in May 2024 with diagnoses including obstructive sleep apnea and congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/5/24, indicated that Resident #106 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS also indicated Resident #106 did not use CPAP in the last 14 days. On 7/23/24 at 8:43 A.M., the surveyor observed Resident #106 in bed with a CPAP machine on his/her bedside table. The CPAP machine and undated tubing was visibly soiled with a buildup of grime. Resident #106 said he/she had only been able to use it four times since coming to the facility in May because nobody helped clean the machine, but he/she would like to use it because he/she has sleep apnea and has trouble breathing at times. On 7/24/24 at 3:24 A.M., Resident #106 awake and was sitting up in bed, not wearing CPAP mask. The CPAP machine was on his/her bedside table. The CPAP machine and undated tubing was visibly soiled with a buildup of grime. Resident said he/she kept waking up unable to catch his/her breath but could breathe now that he/she was awake and sitting up in bed. Resident #106 said he/she couldn't use his/her CPAP because nobody helped clean the machine and it's too hard to clean it by him/herself. On 7/25/24 at 7:59 A.M., Resident #106 was observed lying flat sideways in bed, not wearing the CPAP mask. The CPAP machine was on his/her bedside table. The CPAP machine and undated tubing was visibly soiled with a buildup of grime. Resident #106 was abruptly twitching and shaking and required Nurse #14 and a certified nurse assistant (CNA) assistance to help reposition and elevate Resident #106's head of bed. Nurse #14 said she did not know if Resident #106 had shortness of breath when lying flat. Nurse #14 said Resident #106 had the CPAP in his/her room since admission in May 2024. Resident #106 said to Nurse #14 he/she had wanted to wear it but couldn't because he/she needs it cleaned. Review of Resident #106's physician's progress notes, dated 5/31/24, 6/3/24, 6/5/24, 6/7/24, 6/11/24, 6/14/24, 6/17/24, 6/20/24, 6/21/24, 6/28/24, 7/1/24, 7/2/24, 7/19/24, 7/22/24, and 7/23/24, indicated: - OSA (obstructive sleep apnea): continue with CPAP at night. Review of Resident #106's active physician's orders failed to indicate orders for respiratory care, sleep apnea, CPAP, or ongoing respiratory assessment. Review of Resident #106's entire plan of care failed to address any respiratory care, sleep apnea, CPAP, or ongoing respiratory assessment. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #88's entire medical record failed to indicate Resident had refused to utilize CPAP machine. During an interview on 7/25/24 at 8:04 A.M., Nurse #14 said Resident #106 should have an order and care plan for his/her CPAP machine to ensure the care necessary is provided for its use, such as cleaning. Nurse #14 said staff are responsible for ensuring CPAP machines are cleaned and cared for, and it would never be the responsibility of Resident #106. Nurse #14 said she would have expected nursing to obtain an order or document refusal for CPAP when it was noted to be present on his/her bedside on admission in May. Nurse #14 said a respiratory care plan and a physician's order for daily respiratory assessment should be in place for any residents with respiratory concerns, such as obstructive sleep apnea, but was not in place for Resident #106. During an interview on 7/25/24 at 8:10 A.M., Certified Nurse Assistant (CNA) #4 said her usual schedule is 6 A.M. -2 P.M. and had seen the CPAP machine on his/her bedside since he/she was admitted in May 2024. CNA #4 said she had never seen Resident #106 wearing a CPAP machine when he/she was sleeping and had never offered to clean it. During an interview on 7/26/24 at 10:02 A.M., the Director of Nursing (DON) said any resident with impaired respiratory status, such as sleep apnea, should have a physician's order for daily respiratory assessment and a respiratory care plan in place. The DON said when Resident #106 was admitted with his/her CPAP machine a physician's order should have been obtained for its use. The DON said if Resident #106 had refused to use the CPAP, that would be expected to be documented. The DON said a resident would never be responsible for cleaning their own CPAP, and if Resident #106 had requested to clean it him/herself that should be documented, or care planned but was not. 49880 3. Resident # 92 was admitted to the facility in July 2023 with diagnoses that include obstructive sleep apnea, multiple sclerosis, PTSD, anxiety, low back pain Review of Resident #92's most recent Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. This MDS also indicated Resident #92 did not use CPAP in the last 14 days. On 7/23/24 at 9:14 A.M., the surveyor observed a CPAP machine with tubing and mask attached hanging next to Resident #92's bed. Resident #92 said he/she applies and removes the CPAP him/herself and uses it every night. Review of Resident #92's active physician's orders on 7/26/24 failed to indicate an order for the use of CPAP. Review of Resident #92's active care plan failed to indicate a plan of care for the use of CPAP or the management of obstructive sleep apnea. During an interview on 7/25/24 at 7:23 A.M., Nurse #12 said that he works overnight and takes care of Resident #92. Nurse #12 said that the Resident uses CPAP and usually manages it him/herself. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 11:02 A.M., the Director of Nurses said there should be physician's orders and plan of care in place for the use of CPAP and the diagnosis of obstructive sleep apnea.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338 Based on observations, interviews, and record review the facility failed to ensure care plans were reviewed with the interdisciplinary team (IDT) as required for two Residents (#3 and #24) out of a total sample of 39 residents. Specifically, 1. For Resident #3 the facility failed to review and revise the plan of care related following the removal of a foley catheter (a urinary catheter that is inserted into the bladder). 2. For Resident #24 the facility failed to review and revise the plan of care related to wound care. Findings include: Review of facility policy titled Care Plans, dated as revised 1/2023, indicated each resident of this facility shall be involved in the development and review of his/her plan of care along with his/her family member. -Interdisciplinary team conferences shall be held for each resident at 90-day intervals and more often if needed. The interdisciplinary team shall: -Revise the plan of care, treatment, and services. -Care plans shall be updated at the time of the conference or on the shift immediately following the conference. 1. Resident #3 was admitted to the facility in September 2023 with diagnoses including stroke, acute inflammatory demyelinating polyneuropathy (an autoimmune disorder characterized by weakness and sensory loss in the limbs), and anemia. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #3 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15 and required total assistance with all activities of daily living. Further review of MDS, dated [DATE], did not indicate the Resident #3 had an indwelling catheter. On 7/23/2024 at 7:49 A.M., the surveyor observed Resident #3, while lying in bed. He/she did not have a foley catheter. Review of Resident # 3's physician order, dated 12/1/2023, indicated the foley catheter was discontinued. Review of Resident #3's nursing progress note, dated 12/1/23, indicated Resident #3 had his/her foley catheter discontinued. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current plan of care related to indwelling catheter, dated 10/27/23, indicated Resident #3 had an indwelling foley catheter. During an interview on 7/30/24 at 7:55 A.M., Nurse #9 reviewed the active plan of care with the surveyor which indicated Resident #3 had an indwelling foley catheter. Nurse #9 said the plan of care should have been reviewed and updated after the foley catheter was removed, but it was not. During an interview on 7/31/24 at 10:30 A.M., the Minimum Data Set (MDS) nurse reviewed the active care plan with the surveyor which indicated Resident #3 has an indwelling foley catheter. The MDS nurse said the plan of care should be updated after each assessment and it was not. During an interview on 7/31/24 at 11:56 A.M., the Director of Nursing (DON) said care plans should be reviewed quarterly and as needed and updated to reflect the current plan of care and it was not. 44095 2. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, and protein malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS indicated Resident #24 had four stage 4 pressure ulcers and one unstageable ulcer. Review of Resident #24's plan of care related to actual skin breakdown, dated as revised 5/9/24, indicated: - Follow physician orders for treatment, including flagyl (antibiotic medication used to treat malodorous wounds) to wound bed, dated as initiated on 8/11/22. Review of Resident #24's Treatment Administration Record (TAR) dated June 2024, Medication Administration Record dated June 2024, and physician's orders on 7/25/24, failed to include the use of flagyl to the wound bed. During an interview on 8/1/24 at 4:21 P.M., Nurse #13 said that Resident #24 had not used flagyl in his/her wound for over six months. During an interview on 8/1/24 at 9:10 A.M., the MDS Nurse said Resident #24's skin care plan should have been updated during the most recent review and the flagyl should have been removed from the care plan. The MDS Nurse said that any member of the interdisciplinary team is able to revise resident's plan of care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on record review, policy review and interviews, the facility failed to meet professional standards of quality for two Residents (#16 and #27) out of a total sample of 39 residents. Specifically: 1) For resident #16 the facility failed to implement physician's orders for prevalon boots and an air mattress for a resident with potential for skin breakdown. 2) For Resident #27 the facility failed to ensure medication orders included a correlating medical diagnosis. Findings include: 1. Resident #16 was admitted to the facility in February 2022 with diagnoses of dementia and malnutrition. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #16 scored a 0 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of Resident #16's care plans indicated the Resident had potential for skin breakdown with the following interventions: - Special mattress (e.g. Alternating Air or low air loss mattress) - check function & placement every shift. Set to current weight, initiated 5/23/24. - Treatments as ordered, initiated 5/23/24. Further review of Resident #16's care plans indicated that Resident #16 requires assist with activities of daily living due to cognitive loss, generalized weakness, increased safety risk, lack of balance, and unable to follow simple directions; the Resident required the following levels of assistance: - Dependent with upper and lower body dressing, initiated 5/7/24. - Dependent with chair to bed transfer, initiated 5/7/24. - Dependent with lying to sitting, initiated 5/7/24. - Dependent with rolling left and right, initiated 5/7/24. Review of Resident #16's physician's orders indicated the following active orders: - Low air loss mattress - setting 150 lbs. (pounds). Check setting every shift, initiated 11/8/23. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prevalon boots on when in bed every shift, initiated 5/2/22. On 7/23/24 at 9:04 A.M., the surveyor observed Resident #16 lying in bed, there were prevalon boots placed neatly on a dresser across the room and out of reach of the Resident; the Resident was not wearing prevalon boots. On 7/23/24 at 1:21 P.M., the surveyor observed Resident #16 lying in bed, there were prevalon boots placed neatly on a dresser across the room and out of reach of the Resident; the Resident was not wearing prevalon boots. On 7/24/24 at 3:29 A.M., the surveyor observed Resident #16 lying in bed, there were prevalon boots placed neatly on a dresser across the room and out of reach of the Resident; the Resident was not wearing prevalon boots. The surveyor observed Resident #16's air mattress set to 325 lbs. On 7/24/24 at 10:06 A.M., the surveyor observed Resident #16 lying in bed, the Resident's air mattress set to 325 lbs. On 7/25/24 at 7:55 A.M., the surveyor observed Resident #16 lying in bed, there were prevalon boots placed neatly on a dresser across the room and out of reach of the Resident; the Resident was not wearing prevalon boots. The surveyor observed Resident #16's air mattress set to 325 lbs. On 7/26/24 at 7:54 A.M., the surveyor observed Resident #16 lying in bed, there were prevalon boots placed neatly on a dresser across the room and out of reach of the Resident; the Resident was not wearing prevalon boots. The surveyor observed Resident #16's air mattress set to 200 lbs. On 7/29/24 at 7:25 A.M., the surveyor observed Resident #16 lying in bed, there were prevalon boots placed neatly on a dresser across the room and out of reach of the Resident; the Resident was not wearing prevalon boots. The surveyor observed Resident #16's air mattress set to 200 lbs. During an interview on 7/29/24 at 7:39 A.M., CNA #5 said that Resident #16 does not refuse care and that he/she should be wearing the prevalon boots, but she doesn't know when. CNA #5 said that CNA's do not adjust the settings on the air mattress. During an interview on 7/29/24 at 7:53 A.M., Nurse #15 said air mattresses should be checked every shift and the setting adjusted if needed according to the physician order. Nurse #15 said she would expect orders for prevalon to be followed, and that Resident #15 was at risk for skin breakdown. Nurse #15 said Resident #16 does not refuse care, and that the Resident should be wearing prevalon boots while in bed. During an interview on 7/29/24 at 8:07 A.M., the Director of Nursing (DON) said skin checks should be completed weekly, the DON said that completing skin checks had historically been an issue and that some residents had missing skin checks. The DON said that air mattresses should be checked every shift, and the nurse would be expected to adjust the air mattress to the setting according to the physician order. The DON said she would expect orders for prevalon boots to be implemented. 49880 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of facility policy, titled Physician Orders, dated as revised 10/2022, indicated the following: -It is the policy of the facility to secure physician orders for care and services for residents as required by state and federal law. 1. Physician orders will include the medication and/or treatment and a correlating medical diagnosis or reason. 2. Medication orders will include: e. diagnosis. Resident #27 was admitted to the facility in March 2024 with diagnoses that include dementia, COPD and mood disorder. Review of Resident #27's most recent Minimum Data Set (MDS) Assessment, dated 7/18/24, indicated that the Resident was unable to participate in a Brief Interview for Mental Status exam and was assessed by staff to be have severe cognitive impairment. The MDS further indicated the Resident is dependent on staff for ADLS and the resident takes antipsychotic, antianxiety and antiplatelet medications. Review of Resident #27's physician orders indicated the following orders dated 3/28/24: - Acetaminophen 500 milligrams (mg) by mouth three times daily for prophylactic. - Aspirin 81 mg by mouth once daily for prophylactic. - B-12 oral tablet by mouth once daily for prophylactic. - Verapamil 120 mg by mouth once daily for prophylactic. - Lipitor 20 mg by mouth once daily for prophylactic. - Lisinopril 30 mg by mouth once daily for prophylactic. - Melatonin 6 mg by mouth at bedtime for prophylactic. - Cholecalciferol (Vitamin D) 1000 units by mouth once daily for prophylactic. - Famotidine 20 mg by mouth once daily for prophylactic. - Gabapentin 100 mg by mouth every 12 hours for prophylactic. - Haloperidol (an antipsychotic medication) 0.25 mg by mouth three times daily for prophylactic. - Levothyroxine 75 mcg, by mouth once daily for prophylactic. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 1:26 P.M., the Director of Nurses said an appropriate diagnosis should be in place for every medication and that the indication for use of prophylactic is not appropriate.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on observations, record review and interviews, for three Residents (#51, #76, and #85) out of a total sample of 29 residents the facility failed to provide assistance with activities of daily living (ADLs). Specifically, 1. For Resident #51, the facility failed to provide the necessary services to maintain good nutrition (assistance with meals as per the plan of care). 2. For Resident #76, the facility failed to provide the necessary services to maintain nail grooming. Findings include: Review of the policy, ADL Support, dated as revised 6/2022, indicated that Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); and d. Dining (meals and snacks). 1. Resident #51 was admitted to the facility in February 2017 with diagnoses including dementia, glaucoma, contracture of the right hand, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/6/24, indicated that Resident #51 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS indicated Resident #51 required supervision/ touching assistance with eating. Review of Resident #51's physician's order, dated 10/3/22, indicated: - House diet, regular texture, thin liquids consistency, no bread; head of bed (HOB) elevated during meals. Review of Resident #51's physician's orders, dated 11/27/17, indicated: - lip plate for all meals. - aspiration precautions. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's plan of care titled, GG0130. Self-Care indicated he/she required assist with ADLs due to contractures, hemiplegia/hemiparesis (Right), lack of balance, dated 5/8/24, indicated: - Eating: Supervision/Touching Review of Resident #51's physician's order, dated 7/5/24, indicated: - Skilled Occupational Therapy (OT) Clarification Order: Provide adaptive equipment (AE) - 2 handled sippy cup with lid and lip plate during each meal in order to maximize functional performance with activities of daily living (ADL)-self-feeding task. Effective 7/4/24 Review of Resident #51's care card, active 7/29/24, indicated: - Eating: Supervision/Touching On 7/23/24 at 12:10 P.M. the surveyor observed Resident #51 in his/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. There was no lip plate on his/her tray. There was no sippy cup on his/her tray. On 7/23/24 at 12:19 P.M., the surveyor observed Resident #51 alone in his/her room reading the newspaper and not eating his/her lunch. There was pudding on his/her face, and he/she had pushed raviolis off the far side of his/her plate. On 7/24/24 at 8:18 A.M. the surveyor observed a Certified Nursing Assistant (CNA) deliver Resident #51 his/her breakfast tray. There was one sippy cup on the tray, with 4 different liquids. The CNA left the room and Resident #51 was in his/her room eating alone. Resident #51's roommate was in the room on the other side of the room behind the curtain, there was no staff present. On 7/24/24 at 8:28 A.M., the surveyor observed Resident #51 with three spoonful of cream of wheat on his/her towel draped across his /her chest. Resident #51 was in her/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. On 7/24/24 at 8:45 A.M., the surveyor observed Resident #51 in his/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. Resident #51 had cream of wheat dripping down the right side of his/her face and he/she had 5 spoonful of cream of wheat on his/her towel draped across his/her chest. Resident #51 asked the surveyor to rinse out his/her sippy cup and fill the sippy cup with hot chocolate, I can't drink the hot chocolate unless it's in the cup, I wish I had more than one cup. On 7/24/24 at 8:54 A.M., the surveyor observed a CNA enter Resident #51's room, the CNA said that Resident #51 should have at least two sippy cups so he/she can have a choice of drink. On 7/25/24 at 8:20 A.M., the surveyor observed Resident #51 in her/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. Resident #51 was [NAME] at a donut with a fork on a regular plate. The surveyor observed a donut piece that had fallen off the plate on the far side of plate out of reach. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 12:47 P.M., the surveyor observed Resident #51 in his/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. Resident #51 was eating beef with noodles; the noodles and carrots were pushed off the far side of plate. There was no lip plate provided. On 7/26/24 at 8:15 A.M., the surveyor observed Resident #51 in his/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. Resident #51 had oatmeal all over his/her towel draped across his/her chest. On 7/26/24 at 12:31 P.M., the surveyor observed Resident #51 in her/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. Resident #51 did not have a lip plate. Resident #51 was eating fish and peas that were pushed off the far side of the plate. On 7/29/24 at 8:31 A.M., the surveyor observed Resident #51 in his/her room eating alone, his/her roommate was in the room on the other side of the room behind the curtain, there was no staff present. Resident #51 was not provided a lip plate and was not provided a sippy cup. Resident #51 was eating cut up sausage and there was sausage pushed off the far side of the plate. During an interview on 7/31/24 at 8:12 A.M., Certified Nursing Assistant (CNA) #5 said she did not know Resident #51 needs assistance with meals. During an interview on 7/31/24 at 7:59 A.M., Nurse #7 said Resident #51 eats by him/herself, and she was not aware his/her care plan indicated he/she required supervision/touching assistance. Nurse #7 said the care plan needs to be followed. During an interview on 8/1/24 at 4:23 P.M., Nurse #13 said Resident #51 is a set up and eats on his/her own. During an interview on 7/29/24 at 4:03 P.M., the Director of Nursing (DON) said nursing should provide Resident #51 assistance with meals. 45763 2. Resident #76 was admitted to the facility in June 2024 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 6/12/24, indicated that Resident #76 scored a 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #76 required assistance with personal grooming. Review of Resident #76's Self Care care plan indicated the Resident #76 requires assistance with activities of daily living due to decreased activity tolerance, generalized weakness, increased safety risk and being unaware of his/her personal care needs with the following intervention: - Personal Hygiene: moderate assistance, initiated 6/17/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 7/23/24 at 8:27 A.M., Resident #76's nails were elongated, protruding roughly 3/4th's of an inch past the nail bed. Resident #76 said he/she would like help with cutting his/her nails. On 7/23/24 at 12:17 P.M., the surveyor observed that Resident #76's nails were elongated, protruding roughly 3/4ths of an inch past the nail bed. On 7/25/24 at 8:01 A.M., the surveyor observed that Resident #76's nails were elongated, protruding roughly 3/4ths of an inch past the nail bed. During an interview on 7/25/24 at 9:02 A.M., Certified Nursing Aide (CNA) #13 said nails should be checked daily, and that nail care should be offered if a Resident's nails are observed to be long. CNA #13 said that if a Resident refused nailcare that it would be documented. Review of Resident #76's medical record failed to indicate that the Resident had refused nail care. During an interview on 7/25/24 at 9:12 A.M., Nurse #5 said that nurses will check nails during the weekly skin check, and that if a Resident is not diabetic that the CNA's can cut that Resident's nails. Review of Resident #76's diagnoses failed to indicate a diagnosis for diabetes. During an interview on 7/25/24 at 9:26 A.M., the Nurse Supervisor said CNA's should check for nail length anytime they provide care and offer to cut the nails if they are observed to be long. During a follow-up interview and observation on 7/25/24 at 9:28 A.M., the surveyor and Nurse #5 observed that Resident #76's nails were elongated, protruding roughly 3/4ths of an inch past the nail bed. Nurse #5 said that the Resident's nails need to be trimmed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 44095 Based on observation, record review and interviews the facility failed to provide services to ensure that proper treatment to maintain vision and hearing ability were provided for two Residents (#24 and #62) out of a total sample of 39 residents. Specifically, 1. For Resident #24 the facility failed to follow up on recommendations from 12/19/23 for an outside ophthalmology consult. 2. For Resident #62, the facility failed to follow up on an ear nose and throat (ENT) appointment for hearing loss. Findings include: 1. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, and protein malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #24's physician's orders, indicated the following: - May have Dental, Optometrist, Podiatrist consult as needed, dated 8/10/22. - Ophthalmology consult secondary to change in vision, dated 12/12/22. - Make an ophthalmology consult related to cataracts in both eyes, 10/20/23. Review of Resident #24's nursing progress note, dated 10/20/23, indicated: - Resident was seen this shift by Nurse Practitioner (NP), Resident complained of difficulty with vision due to cataracts in both eyes. NP wrote an order to have an ophthalmology consult. Review of Resident #24's consultant attending physician request for service, dated 12/19/23 and signed by the physician, indicated: - eye care, please have the optometrist examine the resident for the following reasons: glaucoma. Review of Resident #24's consultant eye care report, dated 12/19/23, indicated: Assessment: 1. Cataract, mixed; Both eyes 2. Optic atrophy; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Presbyopia Plan 1. Cataract surgery recommended; ophthalmology consult; Follow-Up: 5-6 months; Referral: Ophthalmology Consult; decreased vision possibly due to cataract versus optic atrophy, please consult with ophthalmology **NEEDS TO BE SEEN AT HOSPITAL** if Resident cannot sit in wheelchair. 2. Monitor; Follow-Up: 5-6 Months; Referral: Ophthalmology Consult; decreased vision caused by this versus cataract, monitor with ophthalmology. 3. Monitor; no improvement w/ glasses. During an interview on 7/23/24 at 12:10 P.M., Resident #24 said he/she has cataracts, and he/she wanted the cataracts removed but nursing never followed up and sent him/her to the ophthalmology appointment. During an interview on 8/1/24 at 4:15 P.M., Nurse #13 said he was not aware of Resident #24's vision issue and not aware Resident #24 needed a follow up for cataract surgery. During an interview on 7/29/24 at 4:06 PM., the Director of Nursing (DON) said nursing should have followed up on the consultant eye care recommendations. 2. Resident #62 was admitted to the facility in February 2024 with diagnoses including chronic kidney disease, diabetes, depression, and obesity. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/8/24, indicated that Resident #62 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #62's physician's orders, indicated the following: - 6/11/24, Please schedule the patient to see ENT at Hospital for ear pain. - 6/14/24, Please schedule the patient with ENT for ear pain. Review of Resident #62's consultant request for service, undated, indicated he/she requested audiology services. Review of Resident #62's provider's progress notes, dated 6/11/24, 6/17/24, 6/21/24, and 7/3/24, indicated the following: - H91.90 - Unspecified hearing loss, unspecified ear: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/4/24: Nursing staff as well as the patient endorse a decrease in hearing. Will order debrox drops (medicated ear drops to remove ear wax) for 4 days, instill 5 drops twice daily. Will then follow up with patient. If no improvement will schedule patient to be seen by ENT. - 4/8/24: Will follow up with patient on Wednesday 4/10 to see if he/she has any more improvement with hearing loss. Will also clean out patient's ears provided that rehab has available equipment. Otherwise, the patient can be scheduled with outpatient ENT. - 4/10/24: Patient is scheduled for ENT appointment on 4/30/24 at 3:30 P.M. Will notify nursing to provide transportation. - 5/1/24: Will contact ENT and reschedule patient's appointment due to him/her not feeling well. Review of Resident #62's physician's progress note, dated 7/5/24, indicated the following: - Chief Complaint/Reason for this Visit: Patient seen for hearing loss. Patient is asking if he/she can go to hospital (specialty hospital) to be seen for his/her hearing loss. - H91.90 - Unspecified hearing loss, unspecified ear: - 7/5/24: Will refer patient to hospital (specialty hospital) for hearing loss. During an interview on 7/25/24 at 3:58 P.M., Resident #62 said that he/she has not seen the ENT but would like to for hearing problems. During an interview on 7/24/24 at 5:10 A.M., Nurse #7 reviewed appointment book and reviewed facility bulletin board in the electronic medical record. Nurse #7 said that there was no documentation to support an ENT appointment was booked related to the physician's order from 6/14/24. During an interview on 8/1/24 at 4:07 P.M., Nurse #13 said that Resident #62 has a hard time hearing, and he had asked the Nurse Practitioner to see Resident #62. Nurse #13 said he was not aware that the NP recommended Resident #62 see the ENT. During an interview on 8/1/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) said that she confirmed the order in the electronic medical record on 6/14/24 for the ENT appointment. The ADON said she told a nurse on the floor about the appointment, but she couldn't remember who she spoke to. The ADON said there had not been an appointment booked. During an interview on 7/25/24 at 10:08 A.M., Nurse Practitioner (NP) #1 said Resident #62 has hearing loss. NP #1 said that Resident #62 required an ENT appointment, but nursing had not scheduled the appointment but should have. During an interview on 7/29/24 at 4:23 P.M., the Director of Nursing (DON) said nursing should have followed up and booked the ENT appointment. The DON said she was unable to provide any evidence of visits from the consultant audiologist.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observations, interviews, policy review, and record review, the facility failed to provide care and treatment to prevent the development of pressure ulcers (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the hips, heels, or elbows) for 4 out of a total sample of 39 residents. Specifically: 1a) For Resident #85, the facility failed to implement treatments and physician orders recommended by the consulting wound physician resulting in a new necrotic skin condition progressing to an unstageable wound leading to osteomyelitis (a bone infection) and sepsis (a life-threatening response to infection) requiring hospitalization and need for a fecal-diverting colostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, that allows digested food to pass out of the body through an external pouch system). 1b) For Resident #85, the facility failed to ensure that an air mattress was set at the appropriate setting to promote wound healing in the presence of a stage IV pressure wound (defined as deep wounds that may impact muscle, tendons, ligaments, and bone). 2a) For Resident #24, the facility failed to implement the physician's order for air mattress settings. 2b) For Resident #24, the facility failed to implement dietician recommendations for wound healing. 2c) For Resident #24, the facility failed to implement wound physician's recommendations for wound care. 3) For Resident #42, the facility failed to ensure nursing accurately transcribed the frequency of a physician ordered topical medication for a stage four pressure ulcer. 4) For Resident #103, the facility failed to implement treatment recommendations by the consultant wound practitioner for a stage IV pressure ulcer. Findings include: Review of the facility policy, titled Pressure Wound Prevention, revised January 2023, indicated, but was not limited to, the following: - Inspect the skin on a daily basis when performing or assisting with personal care or ADLS (activities of daily living). - Evaluate, report and document potential changes in the skin. - Review the interventions and strategies for effectiveness on an ongoing basis. Review of the facility policy, titled Ulcer/skin Breakdown Clinical Protocol, created January 2023, indicated, but was not limited to, the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; - The interdisciplinary team should collectively complete Route Cause Analysis for any newly identified in-house acquired pressure injury. - The wound care specialist/medical provider will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. 1a) Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. Review of Resident #85's Potential Skin care plan, initiated 3/8/23, indicated the Resident had potential for alteration in skin integrity, with the following interventions: - Complete skin condition checks weekly - Dietary interventions/evaluation - Follow MD (Medical Doctor/physician) orders for skin care and treatments (utilize best practice guidelines) Review of Resident #85's Norton Scale for predicting risk for pressure ulcer, dated 2/27/24, indicated the Resident scored an eight, placing the Resident in the high risk category. Review of Resident #85's Skin Only Evaluation, dated 3/6/24, indicated Resident #85 had no skin issues. Review of Resident #85's Skin Only Evaluation, dated 3/11/24, indicated Resident #85 had a new necrotic (the death of body tissue or an organ due to a lack of blood supply) wound on the left buttock, medial area, and that the wound did not have an odor. Review of Resident #85's initial Wound Evaluation and Management Summary, dated 3/12/24, indicated the Wound Physician evaluated the Resident for a rash. The Wound Physician diagnosed Resident #85 with diaper dermatitis and recommended Lotrisone cream (an anti-fungal cream) to be applied twice daily to the affected area and prn (as needed). Review of Resident #85's Treatment Administration Records failed to indicate that the lotrisone cream was implemented. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/29/24 at 10:03 A.M., Nurse #17 said that when changes in skin are identified they should be reported to the NP (Nurse Practitioner)/MD. Nurse #17 said that the Wound Physician will give recommendations to the staff member accompanying her during wound rounds every Tuesday. Nurse #17 said that a Certified Nursing Assistant had initially reported the wound to her, and that the Resident had a wound on the middle of the coccyx and a wound on the left buttocks; Nurse #17 said she had not reported the wound to the physician because the wound did not need the physicians' attention because of how small it was. Nurse #17 said she did not apply lotrisone, and that the aides have been using house barrier cream which was not a new treatment for the newly identified wound in March. During a follow-up interview on 7/30/24 at 8:19 A.M., Nurse #17 said that communication with the physician would be included in a progress note, and in the communication book. Review of the communication book and Resident #85's progress notes failed to indicate that the physician was notified of the new necrotic skin condition identified on 3/11/24. Review of the Nurse practitioner (NP) progress note, dated 3/13/24, failed to indicate that the NP was aware of, evaluated, or initiated treatments for Resident #85's necrotic wound. Review of Resident #85's wound evaluation and management summary, dated 3/19/24, indicated the Wound Physician evaluated the Resident's rash. The Wound Physician recommended lotrisone cream for the diaper dermatitis. During an interview on 7/30/24 at 11:13 A.M., the Wound Physician said that when she is consulted, she does not do a full skin check due to time constraints. The Wound Physician said she was initially consulted for Resident #85 to evaluate a rash on the frontal groin area, and nothing else; as the rash was on the front she may not have evaluated the backside and she was not aware of a necrotic wound when she evaluated the rash. The Wound Physician said this may have been a result of bad communication. Review of Resident #85's Treatment Administration Records (TAR) failed to indicate that the lotrisone cream was implemented. Review of Resident #85's medical record failed to indicate a nursing skin evaluation was completed the week of 3/18/24. Review of Resident #85's physician orders indicated the following discontinued orders: - Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to Sacrum topically one time a day for Wound, initiated 3/23/24, 12 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 5/24/24. - Left butt wound wash with normal saline cover with silicone bordered form dressing every day shift left butt wound, initiated 3/22/24, 12 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 5/24/24. - Wound Consult for left butt wound, initiated 3/25/24, 15 days after nursing had initially identified the Resident's necrotic wound, and discontinued on 4/25/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review Resident #85's progress note, written by NP #2, dated 3/26/24, indicated the following: I was asked to see this pt (patient) because of worsening wounds. Nursing reports they had started as superficial, but now were open and deeper. He/she had not been followed by the wound care team. Consult initiated and wound team saw this resident the AM of 3/26. They will now follow his/her wounds which are pressure related. Further review of Resident #85's progress note, written by Nurse Practitioner (NP), dated 3/26/24, indicated that the consult for the Resident's wound was initiated 15 days after nursing had initially identified the necrotic area. Further review of the progress note indicated that the wound team requested multi-interventions in addition to wound care. During an interview on 7/30/24 at 11:42 A.M., NP #2 said she would expect to be notified of a new skin condition. NP #2 said that her review of systems includes communication with the nurses, and that she does not do a full-skin check as part of her regular evaluation; the NP said that she would only look at skin if a concern is brought to her attention. NP #2 said a staff member will follow the Wound Physician to communicate the recommendations to her, and that she would expect the recommendations to be implemented. NP #2 said that the risk of not implementing the Wound Physician recommendations would be that the wound could get worse, and that the wound could get infected and develop osteomyelitis. NP #2 said she was first notified of the wound on 3/26/24, when nursing reported to her that the wound had developed an odor, and that when she had evaluated the Resident on 3/13/24 she had not been aware of the wound. During an interview on 7/31/24 at 9:16 A.M., Physician #2 said he would expect nursing to notify himself or an NP of a change in skin condition. Physician #2 said a facility nurse should be following the Wound Physician for recommendations, and that the risk of Wound Physician recommendations not being followed would be that the wound would probably get worse if the Resident was not receiving treatment. Review of Resident #85's Wound Evaluation and Management Summary, dated 3/26/24, indicated Resident #85 had an unstageable (due to necrosis) pressure injury on his/her left ischium measuring 2.5 x 2.4 cm (centimeters), and an unstageable (due to necrosis) pressure injury on his/her sacrum measuring 3.9 x 3.7 cm. Further review of the wound evaluation indicated that the duration of both wounds was greater than six days, and that the Wound Physician recommended a house supplement (a calorically and nutritionally fortified drink typically utilized to address weight loss and/or meet assist in meeting nutrient, such as protein, needs) alginate calcium (a gel that promotes wound healing), and santyl (an ointment used to promote the healing of skin ulcers by removing damaged tissue). Review of the nursing progress note, dated 3/27/24, indicated Resident #85 was being transferred to emergency room for evaluation as the resident was very week sic. And oxygen of at 58% at room air. Review of Resident #85's TAR failed to indicate that alginate calcium, or santyl were implemented prior to the Resident's hospitalization on [DATE]. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the hospital discharge paperwork, dated 4/22/24, indicated that Resident #85 presented to the hospital on 3/27/24 with encephalopathy (a broad term for any brain disease that alters brain function), found to be in sepsis with an infected sacral ulcer as the presumed source. Further review of the hospital paperwork indicated that the Resident underwent wound debridement (a procedure that removes unhealthy or dead tissue from a wound to promote healing and prevent infection) on 3/29/24, 3/31/24, 4/5/24, and 4/21/24, and that fecal diversion was indicated to allow for the wound to heal due to the wound's proximity to the anus; on 4/5/24 the Resident underwent a diverting loop sigmoid colostomy creation. The hospital paperwork indicated there was clinical and imaging evidence of osteomyelitis with the sacrum/coccyx bones exposed in the wound. Review of the nursing progress note, dated 4/22/24, indicated that Resident #85 had returned from the hospital with a sacral ulcer with underlying osteomyelitis status post multiple debridement's and the creation of a diverting loop colostomy. Further review of the progress note indicated that the Wound Physician would evaluate the Resident on 4/23/24 to provide guideline on wound vac (a treatment that uses suction to help wounds heal) use [sic]. Review of the Minimum Data Set (MDS) assessment, dated 4/28/24, indicated that Resident #85 scored a 10 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated that Resident #85 had a new Stage IV and a new Stage III pressure ulcer and was at risk for developing pressure ulcers. According to the Mayo Clinic, complications and outcomes of Stage IV pressure ulcers include: - Osteomyelitis, which is characterized by a mixture of inflammatory cells, fibrosis, bone necrosis, and new bone formation. It is associated with nonhealing wounds, surgical flap complications, and an increased length of hospitalization . It may develop within the first 2 weeks of pressure ulcer formation and despite treatment may require amputation in lower extremity cases. - Joint infections (septic arthritis) can damage cartilage and tissue. - Bone infections (osteomyelitis) can reduce the function of joints and limbs. - Long-term, nonhealing wounds can develop into a type of squamous cell carcinoma. - Sepsis (blood infection). Review of the Wound Evaluation and Management Summary, dated 4/23/24, indicated that Resident #85 had a stage IV sacral pressure wound (Stage IV pressure wounds are defined as deep wounds that may impact muscle, tendons, ligaments, and bone) measuring 17 x 17 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement, foley catheter (a medical device that helps drain urine from the bladder) as urine will cause wound vac to lose suction and negative pressure wound therapy to be applied three times per week for 30 days at 125 mmHg (millimeter of mercury, a manometric unit of pressure) continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated on 4/22/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 4/30/24, indicated that Resident #85 had a stage IV sacral pressure wound measuring 17 x 16.8 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement and negative pressure wound therapy to be applied three times per week for 23 days at 125 mmHg continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated on 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's progress notes indicated the Resident was transferred to the emergency roiaognom on [DATE]. Review of the hospital discharge paperwork, dated 5/9/24, indicated Resident #85 presented to the hospital with lethargy, anorexia (abnormal loss of appetite for food), hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and worsening wound drainage. Further review of the hospital paperwork indicated the Resident required intravenous antibiotics for sepsis during hospitalization , and was discharged back to the facility with the recommendation to change the wound vac three times per week. Review of the Wound Evaluation and Management Summary, dated 5/14/24, indicated that Resident #85 had a stage IV sacral pressure wound measuring 16.8 x 16.5 x 4.5 cm and a stage IV pressure wound on the left ischium measuring 2 x 1 x .4 cm. Further review of the Wound Evaluation and Management Summary indicated the Wound Physician recommended a house supplement and negative pressure wound therapy to be applied three times per week for nine days at 125 mmHg continuously. Review of Resident #85's TAR indicated that the wound vac was scheduled to be changed twice a week, initiated 4/22/24. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 5/21/24, indicated that Resident #85 had a stage IV pressure wound measuring 16.8 x 16.7 x 4.8 cm, and that the wound progress was exacerbated due to infection; the Wound Physician recommended a house supplement and sodium hypochlorite solution (dakins) twice daily for 30 days. Further review of the Wound Evaluation and Management summary indicated the Resident had a stage 4 pressure injury of the left ischium measuring 1 x 1 x 0.2 cm, and that the Wound Physician recommended alginate calcium once daily for 23 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's Nurse Practitioner progress note, dated 5/22/24, indicated that the Resident had been seen on 5/21/24 by the Wound Physician who found bone chips in the Resident's wound. Further review of the progress note indicated that the Resident was transferred to the hospital on 5/21/24 for sacral wound for IV antibiotics or hospice. Review of the hospital discharge paperwork, dated 5/24/24, indicated Resident #85 had presented to the hospital after the facility had noticed bone chips in his/her wound. Review of the Wound Evaluation and Management Summary, dated 5/28/24, indicated that Resident #85 had a stage IV pressure wound measuring 17 x 16.8 x 4.8 cm, and that the wound continues to deteriorate; the Wound Physician recommended sodium hypochlorite solution (dakins) twice daily for 23 days. Further review of the Wound Evaluation and Management summary indicated the Resident had a stage 4 pressure injury of the left ischium measuring 1 x 0.9 x 0.2 cm, and that the Wound Physician recommended alginate calcium once daily for 23 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of the Wound Evaluation and Management Summary, dated 6/4/24, indicated that Resident #85 had a stage IV pressure wound measuring 17 x 17 x 4.8 cm, and that the wound was exacerbated by acute osteomyelitis; the Wound Physician recommended a house supplement and sodium hypochlorite solution (dakins) twice daily for 16 days. Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's progress note, dated 7/10/24, indicated the Resident was sent to the hospital as the resident was shaking and pale. Review of the hospital discharge paperwork, dated 7/20/24, indicated Resident #85 presented to the hospital on 7/10/24 with severe sepsis secondary to sacral wound infection requiring admission to the ICU (intensive care unit) for pressor support. Further review of the hospital discharge paperwork indicated the Resident's wound was debrided on 7/11/24, the Resident required IV antibiotics for sepsis, a urinary foley catheter was placed on 7/11, 80 days after the Wound Physician initially recommended the placement of the foley catheter, and a wound vac was placed on 7/13 with instructions to be changed on Monday, Wednesday, and Friday. Review of the most recent Wound Evaluation and Management Summary, dated 7/23/24, indicated that Resident #85 had a stage IV pressure wound measuring 16 x 15.5 x 4.8 cm, and that the wound was not at goal; the Wound Physician recommended a house supplement and to change the wound vac three times per week. Review of Resident #85's physician orders indicated the following discontinued orders: - Change (wound vac) dressing every 3 days and PRN (as needed), initiated on 4/22/24 and discontinued on 5/24/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's physician orders and diet manager change history failed to indicate that a house supplement was implemented. Review of Resident #85's physician orders indicated the following active orders: - Change Negative pressure wound therapy (wound vac) dressing every 3 days and PRN, initiated 7/20/24. - Change foley catheter as needed, initiated 7/20/24. Review of Resident #85's TAR indicated that foley care was initiated on 7/20/24. Further review of Resident #85's physician orders, hospital discharge orders, diet manager change history, and TAR indicated that the lotrisone cream, and house supplement recommended by the Wound Physician were never initiated, a wound treatment was not ordered until 3/23/24, 12 days after nursing had initially identified the necrotic wound, and that a foley catheter was not placed until 7/11/24, 80 days after the Wound Physician initially recommended the placement of a foley catheter. Review of Resident #85's MAR failed to indicate that the wound vac was ever changed three times a week as recommended by the Wound Physician. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/23/24, indicated that Resident #85 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 had an unhealed Stage IV pressure ulcer and was at risk for developing pressure. On 7/30/24 at 8:01 A.M., the surveyor observed the Wound Physician and the Unit Supervisor performing wound care on Resident #85. The wound was larger in diameter than a cantaloupe with a bright red wound bed and some yellow-colored tissue. During an interview on 7/29/24 at 2:52 P.M., the Nurse Supervisor said that if a Resident is noted with a change in skin condition that a skin assessment will be done, that the change would be reported to the physician, and that a treatment order would be placed. The Nurse Supervisor said that he accompanies the Wound Physician during her wound rounds on Tuesdays. The Nurse Supervisor said that it was his responsibility to print the Wound Physician recommendations and to present them to the NP and that the signed recommendations will be placed in the physical chart. The Nurse Supervisor said that he never has the time to follow this process because he is always working on a cart, as a result the Wound Physician's recommendations for treatment changes don't get implemented. Review of Resident #85's medical chart failed to indicate that the Wound Physician's recommendations for lotrisone, a house supplement, foley catheter placement, or a three day a week wound vac change were reviewed by the NP or MD. During an interview on 7/31/24 at 3:05 P.M., NP #1 said she would not disagree with the Wound Physician recommendations and that the recommendations sound reasonable, but cant recall if she was aware of them. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/30/24 at 7:36 A.M., the Wound Physician said her expectation was that the nurse rounding with her should print, review and implement her recommendations. The Wound physician said she was not aware that her recommendation for lotrisone was not implemented. The Wound physician said the wound vac should have been changed three times a week, she was not aware that it was ordered for two times a week and that was not the correct order. The Wound Physician said she had recommended a foley catheter but that it wasn't implemented by the facility. 1b) Review of the facility policy, titled Supportive surfaces - air mattress, indicated, but was not limited to, the following: Low air mattress use is indicated as follows: - To assist in the treatment and/or prevention of pressure ulcers as part of the holistic program of pressure ulcer management - As part of a pain management program when indicated for resident comfort Settings: - The patient weight indication is a close approximation of the correct setting. If the mattress is too soft or firm, simply press the up or down arrows to adjust, as necessary. - It may be necessary to alter weight setting to get optimal comfort setting for patients. If patient feels that the bed is too firm/soft, lower or increase weight setting one increment at a time and wait for stabilization before evaluating. Review of Resident #85's physician orders indicated the following active order: - Air Mattress to be for pressure relief. Set to manufacturers recommendations check functionality every shift Review of Resident #85's most recent weight reading, dated 7/20/24, indicated the Resident weighed 141 lbs. On 7/23/24 at 9:15 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. (pounds). On 7/25/24 at 9:42 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. On 7/25/24 at 12:01 P.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. On 7/26/24 at 7:56 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. On 7/29/24 at 10:32 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 7/31/24 at 3:17 A.M., the surveyor observed Resident #85 in bed, his/her air mattress was set to nine, which was the highest setting denoted by 350 lbs. Resident #85 said his/her bed was not comfortable, and that it was too firm. During an observation and interview on 7/31/24 at 3:22 P.M., Nurse #8 said the air mattress should be set to Resident #85's weight, and that the risk of an air mattress being too firm is that it would delay wound healing. The surveyor and Nurse #8 observed Resident #85 in bed, his/her air mattress was set to 9. Nurse #8 said the air mattress should not be set to nine because the Resident did not weight 350 lbs., and that the air mattress was too firm. 44095 2. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, and protein malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #24 required total dependence for toileting and bed mobility and he/she had functional limitations in range of motion on both sides of his/her upper and lower extremities. The MDS indicated Resident #24 had four stage 4 pressure ulcers and one unstageable ulcer. Review of Resident #24's ADV - LN: Norton Scale for Predicting Risk of Pressure Ulcer, dated 1/30/24, 5/24/24, and 7/23/24, indicated Resident #24 was at high risk for skin breakdown as evidenced by a score of 5. Review of Resident #24's ADV - LN: Norton Scale for Predicting Risk of Pressure Ulcer, dated 4/26/24, indicated Resident #24 was at high risk for skin breakdown as evidenced by a score of 7. 2a. On 7/23/24 at 8:10 A.M., 7/23/24 at 9:55 A.M., 7/23/24 at 12:10 P.M., 7/23/24 at 3:21 P.M., 7/24/24 3:05 A.M., 7/24/24 at 7:23 A.M., 7/24/24 at 10:03 A.M., 7/25/24 at 6:42 A.M., 7/25/24 at 8:34 A.M., 7/25/24 at 11:54 A.M., 7/25/24 at 12:50 P.M., 7/25/24 at 4:06 P.M., 7/26/24 at 6:50 A.M., 7/26/24 at 12:31 P.M., and on 7/29/24 at 6:56 A.M., the surveyor observed Resident #24 in his/her bed on an air mattress set to 325. Review of the Resident #24's most recent weights in the electronic medical record indicated the following: - 5/3/24 - 167.0 pounds (lbs) - 7/25/24 - 161.2 lbs Review of Resident #24's physician's order, dated 11/8/22, indicated: - Low Air Mattress - setting 250. Check setting and function every shift. Review of Resident #24's plan of care related to actual skin breakdown, dated as revised 5/9/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Low Loss Air Mattress in place. Check for proper function and ensure proper setting, every shift and as needed. Review of Resident #24's Treatment Administration Record (TAR), dated July 2024, indicated nursing implemented air mattresses setting (set to 250) as ordered on 7/23/24, 7/24/24, 7/25/24, 7/26/24, and 7/29/24. However, based on observations of Resident #24's air mattress was not set to the correct setting. During an interview on 7/29/24 at 7:08 A.M., Certified Nurse Assistant (CNA) #1 said CNAs do not adjust air mattress settings and she said Resident #24 has skin wounds. During an interview on 7/29/24 at 7:10 A.M., Nurse #11 (who had just completed her overnight shift 11:00 P. M., to 7: 00A.M.) said Resident #24 has multiple wounds and he/she uses an air mattress for wound healing. Nurse #11 said air mattress settings are set according to physician's order based on the Resident's weight and CNAs do not adjust air mattress settings. Nurse #11 said she is supposed to verify physician's orders every shift and the orders are documented on the TAR. 2b. Review of Resident #24's dietitian's note, dated 6/30/24, indicated: - Suggest Vitamin C 500 mg twice daily, Zinc 220 mg x 30 days, MVI (multivitamin) with minerals for wound healing. Discussed with nursing. Further Review of Resident #24's medical record failed to include documentation to support nursing implemented the dietitian's recommendations. Review of Resident #24's risk meeting note, dated 7/8/24, indicated: - Resident reviewed by interdisciplinary team (IDT) at Risk meeting. Resident bedbound by preference/discomfort, wounds, weights. During an interview on 7/30/24 at 1:50 P.M., the Dietician said her recommendations for weekly weights, vitamin C and zinc 220 were not implemented by nursing but should have been. 2c. Review of Resident #24's consultant wound evaluation and summary, dated 7/2/24, indicated the following: -Site 7: Stage 4 Pressure Wound of the right ischium. Continue: Alginate calcium apply once weekly for 9 days. -Site 10: Stage 4 Pressure Wound of the left ischium. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Continue: Alginate calcium apply once daily for 9 days; Skin sub application (restorigin, is a placental tissue allograft that is used as a protective barrier in wound care applications. The natural properties of amniotic tissue provide mechanical protection and growth factors to aid in the management of acute and chronic wounds) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. Foam silicone boarder apply once daily for 9 days. -Site 12: Stage 4 Pressure Wound Sacrum. Continue: Alginate calcium apply once daily for 9 days; Skin sub application (restorigin) apply once weekly for 7 days: DO NOT REMOVE or disturb the wound bed. Change the secondary dressing(s) with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indicated next visit. Foam silicone boarder & faced apply once daily for 30 days. -Site 13: Stage 4 Pressure Wound of the left, lateral ankle. Continue: Santyl apply once daily for 23 days; Alginate calcium apply once daily for 23 days. -Site 15: Unstageable (due to necrosis) Pressure Wound of the right buttock., Continue: Alginate		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 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. 50338 Based on record review, policy review, observations and interviews the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one Resident (#35), out of a total sample of 39 Residents. Specifically, for Resident #35, the facility failed to apply left wrist splint daily to left upper extremity. Findings include: Review of policy, titled Appliances-Braces-Slings-Splints, dated as revised 10/22, to protect the safety and well-being of residents, and to promote quality care, the facility uses appropriate techniques and devices for appliances, splints, braces, and slings. To assure all splints, braces, slings, etc. are used appropriately and cared for properly and upper and lower extremities are maintained in a functional position. -Therapy: -teaches resident and nursing staff on how to use, don and doff, care for appliance. -Nursing: -ensures proper schedule for donning (putting on) and doffing (taking off) appliance is known by CNA staff and provides appropriately sign off task options. -ensure staff is aware where device is stored and cared for. -checks skin integrity at least before and after application. -release devices/appliances per physician order. Resident #35 was admitted to the facility in February 2024 with diagnosis including a stroke with left side affected, diabetes, and chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/22/24, indicated that Resident #35 was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS also indicated he/she required total assistance with activities of daily living and had impairment of Range of Motion (ROM) on upper extremity of one side. On 7/23/24 at 9:31 A.M., Resident #35 was observed lying in bed. The Resident was observed to have a left hand in closed position, making a fist. He/she was unable to open his/her hand when asked by surveyor and was not observed to be wearing a splint. At this time, Resident #35 said he/she had not had splint on in a long time. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 3:45 A.M., and 9:05 A.M., Resident #35 was observed lying in bed. The Resident was observed to have a left hand in closed position, making a fist and was not observed to be wearing a splint. On 7/25/24 at 7:03 A.M., Resident #35 was observed lying in bed. The Resident was observed to have a left hand in closed position, making a fist and was not observed to be wearing a splint. On 7/26/24 at 7:17 A.M., Resident #35 was observed lying in bed. The Resident was observed to have a left hand in closed position, making a fist and was not observed to be wearing a splint. On 7/29/24 at 7:09 A.M., Resident #35 was observed lying in bed. The Resident was observed to have a left hand in closed position, making a fist and was not observed to be wearing a splint. Review of physician's order, dated 2/28/24, indicated carpal tunnel wrist splint apply to left wrist one time a day for left wrist pain for Resident #35. Review of physician's progress note, dated 2/28/24, said Resident #35 complained of pain related to left wrist carpal tunnel and that he/she requested a splint for left wrist to treat her carpal tunnel. Review of physician's order, dated 3/20/24, indicated Velcro splint left wrist for Resident #35. Review of physician's progress note, dated 3/20/24, said Resident #35 reports having left forearm pain and that he/she normally has a left-sided hemiparesis from a previous stroke and is not able to move this arm and that he/she is requesting sling for left forearm and occupational therapy. Review of physician's order, dated 3/28/24, indicated skilled occupational therapy (OT) to include patient/caregiver education and orthosis management. Review of Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 3/28/24, said resident is at risk for contracture to left wrist/hand and goal is for Resident #35 to wear a resting hand splint on left hand for up to four hours to prevent contracture and maintain joint integrity. Further review of Resident #35's medical record failed to indicate nursing transcribed the physician order for left resting hand splint as recommended by OT and there was no documentation to support that nursing implemented this order. Review of Occupational Therapy Discharge Summary dated 6/7/24, Resident #35 can tolerate approximately six to eight hours splint wear and that education/training provided with functional maintenance plan (FMP) in place and staff educated on contracture management. Review of FMP: -splint and brace program established/ trained: left resting hand splint. - gently stretch wrist and digits. -complete hand hygiene and skin check daily. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Donn (put on) splint in A.M. after hand hygiene ensuring hand is thoroughly dried, able to tolerate six-eight hours or to her tolerance. -position left hand over splint, securing straps. Ensure one finger can easily run underneath the straps. Review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) from February 2024 through July 2024 failed to include an order for Resident #35 to wear a splint to his/her left wrist were implemented by nursing. During an interview on 7/29/24 at 7:53 A.M., Certified Nursing Assistant (CNA) #6 said she was unaware Resident #35 required a splint. During an interview on 7/29/24 at 7:55 A.M., Nurse #8 said she was aware Resident #35 required a splint and that she puts it on when Resident #35 gets out of bed. Nurse #8 and surveyor reviewed physician order that failed to include wearing schedule for Resident #35's splint. During an interview on 07/29/24 02:34 P.M., Occupational Therapist (OT) #1 said she discharged Resident #35 from OT and wrote FMP for left hand splint. OT #1 said she writes up FMP and attempts to review with staff members on various shifts including any training and for use of equipment as needed and have staff demonstrate their understanding. During an interview on 7/31/24 at 11:50 A.M., the Director of Nursing (DON) said a resident that requires a splint should have an order in place that includes the times of use and the order should be scheduled on the TAR. The DON said that a care plan should be implemented to address use of splint to prevent further decline in range of motion.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 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** 49880 Based on observations, interviews and record review the facility failed to provide adequate supervision to Residents on one of three units. Specifically, staff were observed sleeping on the [NAME] unit during the overnight shift (11:00 P.M. to 7:00 A.M.) on 7/24/24. Findings Include: Review of the General Code of Conduct, dated as revised November 16, 2022, indicated the following: -At [this facility], we expect that the high degree of skill and dedication is shown by our staff will make disciplinary actions necessary only on rare occasions. -Listed below are some examples of behavior and conduct that would result in some form of disciplinary action up to and including immediate termination. *Sleeping on the job. During initial screening on 7/23/24, four Residents on the [NAME] unit, a sub acute unit per the facility assessment, reported that staff are sleeping on the overnight shift. Residents said call light response times are long on the overnight shift. On 7/23/24 at 2:12 P.M., Resident #44 said staff are sleeping in the front room, I see them when I go out to smoke in the middle of the night. They sleep in reclining chairs in the hallway and even in the shower chair, which they pull into the hall. On 7/26/24 at 12:16 P.M., Resident #263 said he/she had concerns about staff sleeping in beds and in dining room as recent as Wednesday, 7/24/24. During a phone interview on 7/23/24 at 10:26 A.M., the Ombudsman's office reported that they receive calls from the facility at all hours of the night from residents reporting that staff are sleeping on the units and that staff get angry when they are woken up by a resident. The Ombudsman's office said that staff have been actively found sleeping on couches in the center, covered in blankets, and even in empty resident beds. On 7/24/24 at 2:36 A.M., two surveyors entered the [NAME] Unit on the first floor. The census on the unit was 30. There was one Nurse and two Certified Nursing Assistants (CNA) on the unit. One CNA was noted to be laying in a reclining chair in the hallway, covered with a blanket from her neck to her feet and had her feet elevated on a stationary chair at the end of the recliner chair. She was observed with her eyes closed. On 7/24/24 at 3:33 A.M., the Maintenance Director said he was in the building to perform sleeping rounds. He said that the management team is aware of a concern with sleeping staff. He said he drew the short stick and it was his turn today to check. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/24 at 6:33 A.M., the Administrator said he was aware of sleeping CNA's overnight and that the nurse working on the over night shift had notified him that a CNA was sleeping on the [NAME] Unit when the survey team entered the building. Social Worker #1 was also present at this time and said that it was disappointing to hear that staff were sleeping because they depend on the staff to monitor and take care of the residents overnight in the facility. During an interview on 7/24/24 at 7:12 A.M., Nurse #12 said that he called the administrator over night to let him know that a CNA was sleeping on the unit. He said he did not know whether or not this particular CNA had slept during a shift in the past, but he said he knew she was tired because it was her 3rd or 4th night in a row working. Nurse #12 said that the CNA should not be sleeping at the facility. During an interview on 7/25/24 at 8:26 A.M., the Director of Nurses said that the facility has zero tolerance for staff sleeping while they are working. She said that the expectation is that staff are awake and rounding the units to keep residents safe and should not be sleeping.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48990 Based on observations, interviews and record review, the facility failed maintain professional standards in the managing and caring for urinary catheter devices for one Resident (#41) out of a total sample of 39 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag was not placed directly on the floor. Findings include: Review of the facility policy titled Catheter - Drainage Bag, revised 1/2023, indicated: - Always attach the drainage bag to the bedframe - never to the side rails. - Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. Resident #41 was admitted to the facility in August 2023 with diagnoses including paraplegia (paralysis of the legs), neuromuscular dysfunction of the bladder, and chronic pain. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/11/24, indicated that Resident #41 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #41 had an indwelling catheter. On 7/23/24 at 2:10 P.M., the surveyor observed Resident #41 in bed with his/her urinary catheter drainage bag not attached to the bed frame and laying directly on the floor. It was half full of clear, yellow urine. Resident #41 said he/she was paralyzed from the chest down and staff takes care of his/her urinary catheter every shift. The surveyor made the following additional observations of Resident #41: - On 7/23/24 at 3:24 P.M., his/her urinary catheter drainage bag was not attached to the bed frame and laying directly on the floor. - On 7/24/24 at 3:43 A.M., his/her urinary catheter drainage bag was not attached to the bed frame and laying directly on the floor. - On 7/24/24 at 8:44 A.M., his/her urinary catheter drainage bag was not attached to the bed frame and laying directly on the floor. - On 7/29/24 at 1:51 P.M., his/her urinary catheter drainage bag was not attached to the bed frame and laying directly on the floor. Nurse #14 looked down and stepped directly over urinary catheter drainage bag during wound care. Nurse #14 left room without attaching urinary catheter drainage bag to bed frame or providing a barrier between the urinary catheter drainage bag and the floor. Review of Resident #41's physician's order, initiated 8/26/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Suprapubic catheter care. Measure output for indwelling catheter q (every) shift. Review of Resident #41's plan of care related to his/her suprapubic catheter, revised 7/15/24, indicated: - Provide catheter care per policy. Review of Resident #41's plan of care failed to indicate refusal of catheter drainage bag to be hanging from the side of the bed. During an interview on 7/24/24 at 9:01 A.M., Certified Nurse Assistant (CNA) #3 said Resident #41's urinary catheter drainage bag should not be directly on the floor. CNA #3 said if the urinary catheter drainage bag needed to be on the floor for any reason there should be a barrier, such as a towel, between the urinary catheter drainage bag and the floor. During an interview on 7/24/24 08:45 A.M., Nurse #14 said urinary catheter drainage bags are supposed to be attached to the bedframe and not directly touch the floor. Nurse #14 said if the urinary catheter drainage bag needed to be on the floor for any reason there should be a barrier, such as a basket, between the urinary catheter drainage bag and the floor. During an interview on 07/26/24 10:02 A.M., the Director of Nursing (DON) said if Resident #41 had refused to have his/her urinary catheter drainage bag attached to the bedframe then it should be care planned. The DON said urinary catheter drainage bags should never be placed directly touching on the floor without a barrier.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on interview, record review, and observation the facility failed to ensure seven residents maintained acceptable parameters of nutritional status out of a total sample of 39 residents. Specifically, the facility failed to: 1) For Resident #85 the facility failed to assess the nutritional status of and implement pertinent interventions for the Resident who developed a necrotic skin area which worsened to two unstageable wounds and experienced significant weight loss. 2) For Resident #68 the facility failed to address a significant weight loss in a timely manner. 3) For Resident #16 the facility failed to obtain weights as ordered, and address a significant weight loss for in a timely manner. 4) For Resident #24 the facility failed to implement a therapeutic diet as ordered by the physician, failed to identify, and address a potential significant weight loss, and failed to implement recommendations by the Dietitian. 5) For Resident #42, the facility failed to implement dietitian recommendations for prosourse (a liquid protein supplement), zinc, vitamin c, and weekly weights. 6) For Resident #50, the facility failed to implement dietitian recommendations for prosourse (a liquid protein supplement), zinc, vitamin c. 7) For Resident #35, the facility failed to assess the nutritional status in a timely manner, obtain weights as ordered by the physician and assess for a potential weight loss. Findings include: Review of the facility policy, titled Weighing the Resident revised January 2023, indicated, but was not limited to, the following: 1. Each resident/patient will be weighed within 24 hours of admission. 2. Weights will be obtained and recorded: - Upon admission - Weekly for the first four weeks, - Then either monthly or more frequently if clinical condition warrants or as ordered by the physician. 3. Any unplanned weight loss/gain is to be reported to the physician, family/responsible party, dietitian, nursing supervisor and addressed at the weekly at risk meeting. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Re-weigh of resident/patient is required with fluctuation of 3 lbs. from previous weight, with licensed nurse observation/validation. Also with: a. 5% loss or gain in one month b. 7.5% loss or gain in three months c. 10% loss or gain in six months Review of the facility policy, titled Pressure Wound Prevention, revised January 2023, indicated, but was not limited to, the following: Poor Nutrition 1. Dietitian will assess nutrition and hydration and make recommendations based on the individual resident's assessment. 2. Monitor nutrition and hydration status. 3. Monitor laboratory values, notify physician when appropriate. 4. Encourage proper dietary and fluid intake. 5. If a normal diet is not possible, talk to physician about supplements. 6. Administer vitamins, mineral and protein supplements in accordance with physician orders and dietitian recommendations. Pressure ulcers can diminish global life quality, contribute to rapid mortality in some patients and pose a significant cost to health-care organizations. Accordingly, their prevention and management are highly important. Nutritional deprivation and insufficient dietary intake are the key risk factors for the development of pressure ulcers and impaired wound healing. Unplanned weight loss is a major risk factor for malnutrition and pressure ulcer development. Suboptimal nutrition interferes with the function of the immune system, collagen synthesis, and tensile strength. Nutritional status plays a central role in the process of wound healing. Malnutrition accompanies a poor outcome and brings about higher morbidity and mortality. Malnutrition should be recognized rapidly and treated accordingly in all patients suffering from pressure ulcers. Malnutrition impedes pressure ulcer healing. Although the ideal nutrient intake to encourage wound healing is unknown, increased needs for energy, protein, zinc, and Vitamins A, C, and E have been documented. High-protein oral nutritional supplements are effective in reducing the incidence of pressure ulcers by 25% in patients at risk. Energy, protein, arginine, and micronutrients (Vitamins A, C, and zinc) are all vital in the wound healing. Proteins are the most important macronutrients since it is indispensable for the repair of tissues. Pressure Ulcer and Nutrition NIH 2018 Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. Review of Resident #85's Potential Skin care plan, revised 4/29/24, indicated the Resident had potential for further alteration in skin integrity, with the following interventions: - Dietary intervention/evaluation, initiated 3/8/23 Review of Resident #85's Nutrition care plan, initiated 3/10/23 and revised 7/1/24, indicated the Resident was at risk for weight loss secondary to esophageal dysmotility, pressure wounds, and mechanically altered diet with a goal for the Resident to remain greater than 190 lbs. (pounds). The following interventions were listed: - Diet consult PRN (as needed), initiated 3/10/23 - Monitor weight per facility policy as ordered, initiated 3/10/23 -Diet as ordered Regular diet, Puree texture, initiated 3/10/23 Review of Resident #85's Self-care care plan, initiated 3/6/24 and revised 5/17/24, indicated the Resident required assistance with activities of daily living related to right side hemiplegia, decreased endurance and fatigues easy. Further review of the care plan indicated the Resident was dependent on staff assistance with eating. Review of Resident #85's most recent comprehensive nutrition assessment, dated 11/14/23, indicated the following: - The Resident did not meet criteria for malnutrition. - A goal for the Resident was to maintain his/her weight. - The Resident's skin was intact. - An intervention to monitor and evaluate the Resident's weight, diet, intakes, skin, labs, mood, and food preferences. On 07/31/24 at 03:17 P.M. the surveyor observed Resident #85 in bed. The Resident appeared cachectic (physical wasting with loss of weight and muscle mass due to disease) as evidence by protruding clavicles, scooping/hallowing temporal region, and thin quadriceps with prominent bones in the patellar region. Review of Resident #85's skin check, dated 3/6/24, indicated Resident #85 had no skin issues. Review of Resident #85's skin check, dated 3/11/24, indicated Resident #85 had a new necrotic wound on the left buttock, medial area, and that the wound did not have an odor. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review Resident #85's progress note, written by Nurse Practitioner #2, dated 3/26/24, indicated the following: I was asked to see this pt (patient) because of worsening wounds. Nursing reports they had started as superficial, but now were open and deeper. He had not been followed by the wound care team. Consult initiated and wound team saw this resident the AM (morning) of 3/26. They will now follow his/her wounds which are pressure related. Review of Resident #85's wound evaluation and management summary, dated 3/26/24, indicated Resident #85 had an unstageable (due to necrosis) pressure injury on his/her left ischium measuring 2.5 x 2.4 cm (centimeters), and an unstageable (due to necrosis) pressure injury on his/her sacrum measuring 3.9 x 3.7 cm. Further review of the wound evaluation indicated that the duration of both wounds was greater than six days, and that the Wound Physician recommended a house supplement. Review of the hospital discharge paperwork indicated that Resident #85 presented to the hospital on 3/27/24 with encephalopathy (a broad term for any brain disease that alters brain function), found to be in sepsis with an infected sacral ulcer as the presumed source. Further review of the hospital paperwork indicated that the Resident underwent wound debridement on 3/29, 3/31, 4/5, and 4/21, and that fecal diversion was indicated to allow for the wound to heal due to the wound's proximity to the anus; on 4/5/25 the Resident underwent a diverting loop sigmoid colostomy creation. The hospital paperwork indicated there was clinical and imaging evidence of osteomyelitis (an infection in the bone caused by bacteria) with the sacrum/coccyx exposed in the wound. Review of the Wound Evaluation and Management Summary, dated 4/23/24, indicated that Resident #85 had a stage IV sacral pressure wound (Stage IV pressure wounds are defined as deep wounds that may impact muscle, tendons, ligaments, and bone) measuring 17 x 17 x 4.5 cm. Further review of the Wound Evaluation and Management Summary indicated that malnutrition was a factor complicating wound healing. Further review of Resident #85's medical record failed to indicate any nutritional evaluation or recommendations/orders were implemented for the Resident. Review of Resident #85's weight and vitals summary indicated the following weight readings: 3/7/23 - 199.3 lbs. 6/19/23 - 204 lbs. 11/14/23 - 203.4 lbs. 2/2/24 - 200.4 lbs. 3/7/24 - 200.8 lbs. 4/22/24 - 189 lbs. 5/14/24 - 185.4 lbs. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7/20/24 - 141 lbs. Review of the Certified Nursing Assistant (CNA) assignment sheet, dated 6/3/24, indicated Resident #85 weighed 181.2 lbs. Further review of Resident #85's recorded weights indicated that Resident #85 had lost 11.8 lbs. of body weight during hospitalization between 3/7/24 and 4/22/24, and then continued to lose weight. Review of the recorded weights indicated that Resident #85's weight loss reached clinical significance on 5/14/24, indicating the Resident had lost a total of 7.6% of his/her total body weight within 2 months. The weight recorded in the CNA assignment book confirms a trend of weight loss, and review of the weight records indicated the Resident had lost an additional 40 lbs. of body weight on 7/20/24, indicating an additional, clinical significant loss of 22.2% of his/her total body weight lost in a month, 25.4% of his/her total body weight lost in three months, or 29.2% of his/her total body weight lost in six months. Review of Resident #85's recorded weights failed to indicate that a reweight was obtained for the weight taken on 4/22/24 until 22 days later, for the weight taken on 5/14/24 until 20 days later, for the weight taken on 6/3/24 until 47 days later, and that a reweight was never obtained to confirm the weight reading on 7/20/24. Review of Resident #85's medical record indicated the Resident was hospitalized again on 5/9/24, 5/22/24, and 7/10/24 for wound-related reasons. Review of the hospital discharge paperwork, dated 5/9/24, indicated the Resident met criteria for severe calorie-protein malnutrition, required enteral nutrition via a nasogastric tube (a tube placed through the nose terminating directly in the stomach used to provide nutrition formula) during the hospitalization, and the hospital recommended to continue supplemental nutrition at the long-term care facility. Review of the hospital discharge paperwork, dated 7/10/24, indicated the Resident appeared cachectic and that the Resident had presented with severe sepsis secondary to his/her sacral wound requiring admission to the ICU (intensive care unit). Further review of Resident #85's medical record failed to indicate any nutritional evaluation or recommendations/orders were implemented for the Resident. Review of Resident #85's medical record indicated he/she was evaluated by the Registered Dietitian (RD) on 7/1/24, 112 days after the necrotic skin condition was first identified, and 48 days after Resident #85's weight loss reached clinical significance. Review of the RD's progress note, dated 7/1/24, indicated the Resident had lost weight and recommended Proheal (a liquid protein supplement) 30cc tid (three times a day) (providing 45 gm elemental protein), Vitamin C 500mg bid, Zinc 220mg x 30 days, and weekly weights. Review of the most recent Wound Evaluation and Management Summary, dated 7/23/24, indicated that Resident #85 had a stage IV pressure wound measuring 16 x 15.5 x 4.8 cm, and that the wound was not at goal; the Wound Physician recommended house supplements. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #85 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 was at risk for developing pressure ulcers and that the Resident had an unhealed Stage IV pressure ulcer. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's medical record indicated that the Wound Physician recommended house supplements on 3/12/24, 3/19/24, 3/26/24, 4/23/24, 4/30/24, 5/14/24, 5/21/24, 5/28/24, 6/4/24, 6/11/24, 6/18/24, 6/25/24, 7/2/24, 7/9/24 and 7/23/24. Review of Resident #85's physician orders, dining manager change history report, and care plans failed to indicate that any nutrition interventions were ever initiated for Resident #85, including the house shakes recommended by the Wound Physician or the Proheal, Vitamin C , Zinc, and weekly weights recommended by the RD. Review of the At Risk documentation indicated that meetings were held on 5/8 and 7/8 but failed to indicate nutrition interventions for Resident #85's weight loss or wounds. Review of the Requested Dietician Information documentation, provided by the facility Administrator, indicated the facility did not have a Registered Dietitian from 1/18/24 to 6/4/24. During an interview on 7/25/24 at 10:12 A.M., the Nurse Supervisor said cardiac residents are weighed every day, and every other resident is weighed monthly and as needed. The Nurse Supervisor said that the nurse will review the weights and enter them into the electronic medical record, and that the nurse should immediately obtain a reweight if there had been a change of three lbs. or more. The Nurse Supervisor said that if the reweight confirms a big change that the physician and RD should be notified, who would be expected to review the weights and address weight changes. During an interview on 7/30/24 at 11:13 A.M., the Wound Physician said that it is always good to have a dietitian involved in wound care and that protein is good for wound healing; she said she tries to get a dietitian involved. The Wound Physician said lack of nutrition interventions will slow down wound healing, increase risk for infection and wound deterioration which can lead to hospitalization . The Wound Physician was not aware that a dietitian was not involved with Resident #85's care. During an interview on 7/25/24 at 1:17 P.M., the RD said that Certified Nursing Aides (CNA's) take weights and give them to nurses, and that if there was a change of three pounds or more from the previous weight that she would expect a reweight to occur within 24 hours. The RD said she would expect to be notified of any confirmed weight changes. The RD said all residents should be assessed quarterly and high risk residents would be assessed monthly; the RD said that an assessment would include weight history, supplement usage, dental status, skin status, past medical history, ideal body weight, feeding status, and past nutrition interventions. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow-up interview on 7/30/24 at 12:22 P.M., the RD said she would expect to evaluate a Resident who had returned from the hospital. The RD said that Residents with wounds have elevated protein needs, and that all wounds require a nutrition assessment and intervention even before they progress to stage III or IV pressure wounds; the RD said that protein is important for wound healing. The RD said she would expect to be notified of significant weight loss or a new wound immediately and would assess the Resident within seven days. The RD said that Resident #85 has a wound and has experienced weight loss; the RD said the Resident requires extra protein and that he/she would not be able to meet his/her protein needs by meals alone. The RD said that the risk of nutrition interventions not being implemented for Resident #85 would be further skin breakdown, and that a Resident can't heal a wound and lose weight at the same time. The RD said the NP was aware of her recommendations and that she had not disagreed with them. The RD said that her recommendations for proheal, vitamin C, zinc, and weekly weights were to promote wound healing. The RD said that house supplements would require a physician order. The RD said she had not been notified of the weight loss recorded on 7/20/24 and she should have. Review of Resident #85's medical record failed to indicate that a comprehensive nutrition assessment was completed for the Resident during a regularly scheduled quarterly MDS assessment on 2/27/24, during significant change MDS assessments on 3/12/24, 4/28/24, or 5/15/24, or when the Resident returned from the hospital on 4/22/24, 5/9/24, 5/24/24 or 7/20/24. During an interview on 7/30/24 at 2:02 P.M., the Food Service Director (FSD) said there have been no interventions for weight loss or wound healing initiated by the kitchen for Resident #85. During an interview on 8/1/24 at 9:17 A.M., NP #1 said she would not have disagreed with the RD's recommendation to implement proheal, vitamin C, zinc, or weekly weights for Resident #85 and that she does not recall if she was notified of the Resident's most recent weight loss on 7/20/24. NP #1 said she was not aware of any nutrition interventions in place for Resident #85, and that she had not initiated any nutrition interventions. During a follow-up interview on 7/31/24 at 12:18 P.M., the Wound Physician said she had recommended Resident #85 receive house shakes to help meet calorie needs to help with wound healing and that she was not aware that her recommendations were not implemented. During an interview on 7/31/24 at 8:09 A.M., the Director of Nursing (DON) said she would expect a Resident who had experienced weight loss to be assessed by an RD as soon as possible, as weight loss would compromise the Resident's health. The DON also said that a change in skin condition should be reported to the Dietitian, as the wound could get worse if untreated. During an interview on 8/12/24 at 10:05 A.M., the Speech Language Pathologist (SLP) said that she had worked with Resident #85 to reduce the risk of aspiration, to trial textures, consistencies, and to strengthen swallowing function. The SLP said that she had not been consulted to address Resident #85's weight loss, and that the speech therapy was to address safety with swallowing. During an interview on 8/12/24 at 19:17 A.M., RD #2 said that she would not consider the Minimum Data Set (MDS) assessment a comprehensive nutrition assessment, and that a comprehensive nutrition assessment would include height, weight, intake, weight changes, wounds, and a review of medications, vitamins and minerals. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2) Resident #68 was admitted to the facility in March 2023 with a diagnosis of Dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #68 scored a 4 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of Resident #68's Potential Skin care plan, revised 4/29/24, indicated the Resident had potential for further alteration in skin integrity, with the following interventions: - Dietary intervention/evaluation Review of Resident #68's Nutrition care plan, initiated 3/22/23 and revised 7/8/24, indicated the Resident was at risk for weight loss secondary to poor PO (per os/by mouth) intake associated with dementia with a goal for the Resident to remain greater than 106 lbs and the following interventions: - Diet consult PRN (as needed) Review of Resident #68's active physician orders indicated the following order: Weight monthly, initiated on 1/1/24. Review of Resident #68's weights and vitals summary indicated the following weight readings: 11/9/23 - 127 lbs. 12/1/23 - 127.4 lbs. 2/2/24 - 128 lbs. 3/7/24 - 129 lbs. 6/13/24 - 110 lbs. 7/8/24 - 106 lbs. 7/8/24 - 106 lbs. Further review of Resident #68's recorded weights indicated Resident #68 had lost 19 lbs. between 3/7/24 and 6/13/24, which is a clinically significant 14.7% of the Resident's total body weight lost in three months. Further review of the recorded weights indicated that a reweight to confirm the 6/13/24 weight loss did not occur until 25 days later. Review of the recorded weights failed to indicate that Resident #68's weight had been recorded in April. Review of the CNA assignment sheet indicated that Resident #68 weighed 86.2 lbs. on 5/14/24 but failed to indicate that a reweight was completed until 6/13/23, 30 days later. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the risk meeting progress note, dated 7/8/24, indicated that Resident #68 was noted with a significant weight loss and that his/her supplement was changed to hi-cal (a calorically concentrated oral nutrition supplement) to increase caloric intake with decreased fluid intake. Review of the dietary progress note, dated 7/8/24, indicated Resident #68 had experienced a weight loss and had recommended to change the Resident's supplement from a house shake to a hi-cal supplement. Review of Resident #68's medical record indicated the first time the Resident's weight loss was first addressed was on 7/8/24, 25 days after the weight loss was initially identified. Review of the dining manager change history failed to indicate the implementation of any nutrition interventions to address Resident #68's weight loss. During an interview on 7/31/24 at 3:20 P.M., CNA #10 said she feels that Resident #68 had lost weight, and that the Resident typically eats 50% of his/her meals. During an interview on 7/25/24 at 10:12 A.M., the Nurse Supervisor said cardiac residents are weighed every day, and every other resident is weighed monthly and as needed. The Nurse Supervisor said that the nurse will review the weights and enter them into the electronic medical record, and that the nurse should immediately obtain a reweight if there had been a change of three lbs. or more. The Nurse Supervisor said that if the reweight confirms a big change that the physician and RD should be notified, who would be expected to review the weights and address weight changes. During an interview on 7/25/24 at 1:17 P.M., the RD said that CNA's obtain weights and give them to nurses, and that if there was a change of three pounds or more from the previous weight that she would expect a reweight to occur within 24 hours. The RD said she would expect to be notified of any confirmed weight changes. During a follow-up interview on 7/30/24 the RD said that Resident #68 had lost weight, and that she is unable to review weights not recorded in the electronic medical record. During an interview on 7/31/24 at 8:09 A.M., the Director of Nursing (DON) said she would expect a Resident who had experienced weight loss to be assessed by an RD as soon as possible, as weight loss would compromise the Resident's health. 3) Resident #16 was admitted to the facility in February 2022 with diagnoses Dementia and malnutrition. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #16 scored a 0 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Review of Resident #16's care plans indicated that the Resident was at nutritional risk given a past medical history of weight loss and dysphagia, with the goal that the Resident will maintain a weight of 165 lbs. Review of Resident #16's weights and vitals summary indicated the following weight readings: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7/3/23 - 178.2 lbs. 9/28/23 - 177.4 lbs. 10/12/23 - 164.4 lbs. 11/9/23 - 172.8 lbs. 12/1/23 - 168.4 lbs. 2/27/24 - 172.4 lbs. 3/7/24 - 158.6 lbs. 5/14/24 - 158.8 lbs. Review of the CNA assignment sheets indicated that Resident #16 weighed 157 lbs. on 7/1/24. Review of Resident #16's recorded weights indicate that the Resident had experienced a clinically significant weight loss of 13.8 lbs., or 8% of the Resident's total body weight within a month between 2/27/24 and 3/7/24. Further review of the recorded weights failed to indicate that a weight was taken in April as ordered by the physician, and that a reweight confirming the 3/7/24 weight loss was completed on 5/14/24, 68 days later. Review of the dining manager change history and physician's orders failed to indicate the implementation of any nutrition interventions to address Resident #16's weight loss. Review of the nurse progress note, dated 7/26/24, indicated the NP was updated regarding Resident #16's fluctuating weights with a new order to monitor the Resident's weight daily for five days. Further review of the progress note indicated that the NP had reported Resident #16 was at risk for unavoidable weight loss due to disease state. Review of Resident #68's medical record indicated the first time the Resident's weight loss was first addressed or acknowledged was on 7/26/24, 141 days after the weight loss was initially recorded. During an interview on 7/25/24 at 10:12 A.M., the Nurse Supervisor said cardiac residents are weighed every day, and every other resident is weighed monthly and as needed. The Nurse Supervisor said that the nurse will review the weights and enter them into the electronic medical record, and that the nurse should immediately obtain a reweight if there had been a change of three lbs. or more. The Nurse Supervisor said that if the reweight confirms a big change that the physician and RD should be notified, who would be expected to review the weights and address weight changes. During an interview on 7/25/24 at 1:17 P.M., the RD said that CNA's obtain weights and give them to nurses, and that if there was a change of three pounds or more from the previous weight that she would expect a reweight to occur within 24 hours. The RD said she would expect to be notified of any confirmed weight changes. The RD said she had not yet assessed Resident #16. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow-up interview on 7/25/24 at 2:58 P.M. the RD said she would have expected a Dietitian to intervene when the weight loss was identified, and that interventions should have been initiated to slow down the rate of weight loss. The RD said a Dietitian should have assessed Resident #16 at the time of the weight loss to rule out unavoidable weight loss, as there could have been other reasons why a resident lost weight other than progressing dementia. During a follow-up interview on 7/30/24 the RD said that she is unable to review weights that are not recorded in the electronic medical record. During an interview on 7/31/24 at 8:09 A.M., the Director of Nursing (DON) said she would expect a Resident who had experienced weight loss to be assessed by an RD as soon as possible, as weight loss would compromise the Resident's health. 44095 4.) For Resident #24 the facility failed to implement a therapeutic diet as ordered by the physician, failed to identify, and address a potential significant weight loss, and failed to implement recommendations by the Dietitian. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, dysphagia, and protein malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #24 was dependent on staff for eating. Review of the Minimum Data Set (MDS) assessments, dated 10/12/23, 1/4/24, 3/21/24, and 6/21/24, indicated that Resident #24 was coded as the following: K0300. Weight Loss, Loss of 5% or more in the last month or loss of 10% or more in last 6 month Coded: No or unknown. On 7/23/24 at 8:10 A.M., 7/23/24 at 12:10 P.M., 7/25/24 at 8:34 A.M., 7/25/24 at 11:54 A.M., and on 7/26/24 at 12:31 P.M., the surveyor observed Resident #24 being fed by a Certified Nurse Assistant (CNA) a puree diet. During an interview on 7/25/24 at 8:34 A.M., Resident #24 said he/she did not like the puree eggs, and he/she continued to say he/she was not sure why the eggs were now pureed. During an interview on 7/31/24 at 8:24 A.M., Certified Nursing Assistant (CNA) #1 said Resident #24 has lost weight, CNA #1 said that she obtains his/her weights and gives them to nursing and CNA #1 said that Resident #24 has been eating a puree diet for about 6 months. CNA #1 said that Resident #1 does not like the pureed eggs. Review of Resident #24's physician's order dated, 5/3/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- No Added Salt (NAS) diet, mechanical soft texture, thin liquids consistency, sodium restriction, high protein, and low fat. Review of Resident #24's diet slip, dated as current on 7/30/24, indicated the following: - NAS Pureed. Further review of the diet slip failed to include the physician's order for mechanical soft texture, high protein, and low fat. Review of Resident #24's plan of care related to nutrition indicated that Resident #24 is at nutritional risk related to increased need for protein and multiple vitamins with minerals to aid in skin integrity. Risk for weight flux with diagnosis of multiple sclerosis and functional quadriplegia, dated as revised 1/4/24, and included the following interventions: - Fortified foods as ordered, initiated on 8/19/22. - Monitor weight per facility policy as ordered, initiated on 8/19/22. - Supplements as ordered; magic cup twice daily, house shake twice daily, and pro source twice daily, initiated on 1/4/24. Review of Resident #24's physician's order, dated 5/23/23, indicated: - Weight monthly one time a day every 25 day(s) Review of Resident #24's Treatment Administration Recorded (TAR), indicated that nursing implemented the physician's order and obtained Resident #24's weight on the following dates: 12/10/23, 1/4/24, 1/29/24, 2/23/24, 3/19/24, 4/13/24, 5/8/24, 6/2/24, 6/27/24, 7/22/24. Further review of the weight tab in the electronic medical record failed to support nursing documented the weights that were obtained as ordered by the physician for the above dates. Review of Resident #24's weight tab in the electronic medical record included the following weights: - 3/8/23 196.6 pounds (lbs) - 11/9/23 186.2 lbs, - 12/1/23 187.0 lbs, - 3/7/24 167.0 lbs, on 12/1/23, the resident weighed 187 lbs. On 3/7/24, the resident weighed 167 pounds which is a -10.70 % Loss. - 5/3/24 167.0 lbs, - 7/25/24 161.2 lbs. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #24's dietitian note, dated 11/9/23, indicated: -Significant weight change, reweight requested. Review of the medical record failed to include that Resident #24 was reweighed as requested by the dietitian. Review of Resident #24's dietitian note, dated 1/4/24, indicated: - A comprehensive nutrition assessment has been completed for Resident. - Weight is stable. - Type of Wounds: significant sacrum/coccyx pressure injuries - Significant weight loss is not noted. The resident does not have a low body mass index (BMI). - The resident does not meet criteria for active malnutrition diagnosis (2 characteristics). Review of Resident #24's physician note, dated 3/3/24, indicated the following: - His/her most recent weight is 187 pounds taken on 12/1/23. Review of Resident #24's nurse practitioner note, dated 5/30/24, failed to document weight loss. Review of Resident #24's physician note, dated 6/10/24, failed to docu[TRUNCATED]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49880 Based on observation, record review, and interview the facility failed to adhere to professional standards for the administration of enteral feeding (nutrition taken through a tube directly to the stomach) for one Resident (#313) out of a total sample of 39 residents. Specifically, for Resident #313 the facility failed to implement physician's orders for his/her head of bed to be elevated, the facility failed to implement physician's orders for water flushes, and the facility failed to label the enteral feeding bag with the contents inside, and with time the enteral feeding was hung, and therefor staff were unable to identify the formula and staff were unable to determine the expiratory date of the formula based on manufactures guidelines. Findings Include: Review of facility policy titled Enteral Feedings, dated as revised 10/2022, indicated the following: -Policy: It is the policy of this center to provide enteral nutrition therapy to residents unable to obtain nutrition orally, when such therapy is ordered by the physician and not clinical contraindicated. [sic] -Procedure: -1. verify the physician order. Resident #313 was admitted to the facility in July 2024 with diagnoses that include dysphagia following cerebral infarction, nontraumatic intracerebral hemorrhage, gastro-esophageal reflux disease. Review of Resident #313's most recent Minimum Data Set (MDS) Assessment, dated 7/15/24, indicated a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating that the Resident has moderate cognitive impairment. The MDS further indicated that Resident #313 is dependent for Activities of Daily Living (ADLS) and uses a feeding tube for nutrition. Review of Resident #313's active physician's orders indicated the following: - Aspiration precautions evert shift: head of bed elevated at greater than 30 degrees at all times, dated 7/12/24. - Osmolite 1.5 full strength at 50 cc/hour continuous via peg tube (a type of enteral feeding tube) for a total volume of 1200 cc/24 hours, dated 7/12/24. - Enteral Feed: every shift free water flush of 38 cc/hour continuous via peg tube for total volume 912 cc/24 hours, dated 7/19/24. - Enteral Feed: water flush 150 cc every 4 hours via bolus, dated 7/20/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer's guidelines for Osmolite 1.5, indicated the following: 3. Do not hang the formula at the bedside for prolonged periods: B. Hang ready-to-use formula that is decanted into a feeding reservoir between 8-12 hours. On 7/23/24 at 8:00 A.M., the surveyor observed Resident #313 sleeping in bed, lying flat with the enteral feeding being administered to the Resident. The enteral formula bag did not include the type of enteral feeding and bag was dated 7/22, there was no time the bag was hung. The water flush was set to 100 milliliters (mL) every 4 hours. On 7/24/24 at 3:18 A.M., the surveyor observed Resident #313 sleeping in bed, lying flat with the enteral feeding being administered to the Resident. The enteral formula bag did not include the type of enteral feeding and bag was dated 7/23 7:00 A.M to 3:00 P.M., the water flush was set to 100 milliliters (mL) every 4 hours. Review of the mini nutritional assessment, dated 7/14/24, indicated a score of 3 which indicated that Resident #313 is malnourished. Review of Resident #313's progress note, dated 7/14/24, indicated that a comprehensive nutrition assessment had been completed. The progress note indicated to flush with 38 cc/hour with water for a free water volume of 912 cc/ 24 hours. Review of Resident #313's care plan, dated 7/15/24, indicated that he/she is at risk for complications from the use of an enteral feeding tube and to administer enteral nutrition and flushes per physicians' orders. Further review of Resident #313's care plan indicated a plan of care for malnutrition, dated 7/16/24, indicating risk for malnourishment as evidenced by Nutritional Screening Tool, dysphagia, and enteral feeds. During an interview and subsequent observation on 7/25/24 at 1:49 P.M., Nurse #2 said that residents on enteral feedings should have their head elevated to at least 30 degrees while in bed. Nurse #2 said the date and time should be labeled on the enteral feed bag but that she did not know what else needed to be on there. The surveyor and Nurse #2 observed Resident #313 lying in bed. Nurse #2 said that the Resident was not sitting up high enough and was at risk of aspiration while lying flat. Nurse #2 observed the pump settings and said that the water flush was not set correctly, but that the Resident had two different flush orders for water, and it needed to be clarified. Nurse #2 also said that the Resident name, enteral feed formula and rate should be included in the labeling of the enteral feed bag. During an interview on 7/26/24 at 11:10 A.M., the Director of Nurses (DON) said that when a resident is receiving an enteral feeding the head of the bed should be elevated at 30-45 degrees. The DON also said the label on the enteral feed bag should include the resident's name, formula, and the rate of the infusion. The DON further said that the nurse administering and monitoring the feeding should confirm that the settings on the pump are correct.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48990 Based on observations, interviews and record review the facility failed to provide care and maintenance of a peripherally inserted central catheter (PICC) consistent with professional standards of practice for two Residents (#263 and #85) out of a total sample of 39 residents. Specifically: 1.) For Resident #263, the facility failed to ensure nursing implemented a PICC line dressing change as ordered by the physician and failed to ensure nursing dated intravenous (IV) tubing. 2.) For Resident #85, the facility failed to ensure that a PICC line dressing was changed within seven days, and that the nursing failed to obtain a physician's order for PICC line dressing changes. Findings include: Review of the facility policy titled PICC Dressing Change, revised 1/2023, indicated: - Transparent dressings are changed every 7 days or sooner if the integrity of the dressing is compromised (wet, soiled, or loose). - Label dressing with date, time, and initials of person performing dressing change. 1.) Resident #263 was admitted to the facility in July 2024 with diagnoses including cellulitis (an infection in the skin and underlying tissue) and osteomyelitis (an infection in the bone). Review of the most recent Minimum Data Set (MDS) assessment, dated 7/18/24, indicated Resident #263 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #263 required IV (intravenous) access and IV medications. Review of Resident #263's active physician's orders indicated: - PICC: Measure external catheter length on admission, with each dressing change, & as needed, one time a day every 7 day(s) change picc [sic] dressing weekly AND as needed, initiated 7/17/24. - PICC: Change administration set (IV tubing), every 24 hours, initiated 7/26/24. Review of Resident #263's Treatment Administration Record (TAR) indicated the following order documented as completed on 7/24/24: -PICC: Measure external catheter length on admission, with each dressing change, & as needed, one time a day every 7 day(s) change picc [sic] dressing weekly. On 7/23/24 at 1:40 P.M., the surveyor observed Resident #263 in bed with IV medications infusing through a PICC. The IV tubing was undated. Resident #263's PICC dressing was dated 7/16/24. Resident #263 said the nurses don't change the tubing every day, but he/she thinks they are supposed to. Resident #263 said he/she thinks sometimes it goes as long as three days, but it depends on who is working. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 07:16 A.M., Resident #263 in bed with IV medications infusing through a PICC. The IV tubing was undated. Resident #263's PICC dressing was dated 7/16/24. On 7/26/24, Resident #263 in bed with IV medications infusing through a PICC. The IV tubing was undated. Resident #263 said he/she was concerned that staff didn't know how to manage his PICC line and IV medications. Resident #263 said he/she had never been offered to have it changed since he was admitted to the facility, and that the PICC dressing in place, which was dated 7/16/24, was from the hospital prior to his/her admission. Resident #263 said he/she would like the PICC dressing changed. Review of Resident #263's entire medical record failed to indicate the Resident had refused the PICC dressing change. During an interview on 7/25/24 at 7:43 A.M., Nurse #9 said the nurse assigned to Resident #263 is responsible for completing any PICC dressing changes ordered or required during their shift. Nurse #9 said IV tubing should always be dated and should be changed every 24 hours. During an interview on 7/26/24 at 12:26 P.M., Nurse #14 said IV tubing should always be dated. Nurse #14 said PICC dressings should be changed according to the physician's orders and should be done every seven days. Nurse #14 visualized Resident #263's PICC dressing, which was dated 7/16/24, and said it should have been changed on 7/24/24, but it was not. Nurse #14 said it should not have been signed off as completed on the Treatment Administration Record (TAR) since it was not. During an interview on 7/29/24 at 8:26 A.M., the Director of Nursing (DON) said PICC dressings should be changed every seven days. The DON said it should not have been documented as done if it was not. The DON said if PICC dressings were refused she would expect that to be documented. 45763 2.) Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 required IV (intravenous) access and IV medications. Review of Resident #85's physician's orders indicated the following: - Visually inspect IV (intravenous) site every shift. Document by letter code of any abnormal finding, initiated on 7/23/24. - Vancomycin HCL (hydrochloride) (an antibiotic) intravenous solution reconstituted 1.5 gm (grams), use 1500 mg (milligrams) intravenously one time a day related to osteomyelitis of vertebra, sacral and sacrococcygeal region, initiated 7/21/24. Review Resident #85's hospital paperwork, dated 7/19/24, indicated a PICC line was placed on 7/17/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 9:42 A.M., the surveyor observed that Resident #85's PICC line dressing was dated 7/17. During an interview and observation on 7/26/24 at approximately 9:30 A.M., Nurse #17 said that PICC line dressings are changed according to the physician order, and that the nurse who worked last night had changed Resident #85's PICC dressing. Nurse #17 said she was not able to find an order for the PICC line dressing change, and that there should be one. Nurse #17 and the surveyor observed the Resident's PICC line dressing, Nurse #17 confirmed that the dressing was labeled 7/25. During an interview on 7/26/24 at 9:44 A.M. Nurse #5 said PICC line dressings should be changed on admission, and then according to the facility policy and physician order. During an interview on 7/31/24 at 12:40 P.M., Nurse #11 said PICC line dressings should be changed every 7 days and as needed. Nurse #11 said she noticed that the PICC line dressing was one day overdue and changed it without an order on 7/25/24. During an interview on 7/26/24 at 9:54 A.M., the Assistant Director of Nursing said that PICC line dressing should be changed on admission and weekly, and that she would expect an order to be in place, and that the nurse should not change a PICC line dressing without an order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 49880 Based on observations, record review, and interview the facility failed to provide respiratory care services in accordance with professional standards of practice for six Residents (#10, #92, #106, #58, #13, and #48) out of a total sample of 39 residents. Specifically, 1. For Resident #10, the facility failed to administer oxygen in accordance with physician's orders. 2. For Resident #92, the facility failed to obtain orders for continuous positive airway pressure (CPAP, a machine that uses mild pressure to keep the breathing airways open during sleep, used to treat obstructive sleep apnea). 3. For Resident #106, the facility failed to provide routine maintenance and cleaning of CPAP machine. 4. For Resident #58, the facility failed to obtain physician's orders for administration of oxygen and failed to date oxygen tubing. 5. For Resident #13, the facility failed to administer oxygen in accordance with physician's orders. 6. For Resident #48, the facility failed to administer oxygen in accordance with physician's orders. Findings Include: Review of facility policy titled Oxygen Administration, dated as revised 10/2022, indicated the following: -Oxygen is administered by Licensed Nurses with a Physician's Order in order to provide a resident with sufficient oxygen to their blood and tissues. Orders should specify the oxygen equipment and flow rate or concentration required as routine or PRN [as needed]. -Procedure: 1. Check the physician's order. If it is unclear, clarification must be obtained. -11. All tubing will be changed at least weekly, more often if soiling with secretions occurs. Review of facility policy titled Respiratory- PAP [positive airway pressure] Equipment, dated as revised 1/2023, indicated the following: -This policy is to instruct the patient in the use of PAP equipment and ensure proper fit and function of the equipment. -PAP machines are used to provide positive airway pressure to the patient's airways. There are generally two indications for PAP therapy. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-a. Patients with Obstructive Sleep Apnea use CPAP/ BIPAP (Bilevel positive airway pressure) to force air through their obstructed upper airways. While they sleep their throat closes in and prevents air from getting into their lungs. This causes their oxygenation to drop and their carbon dioxide to rise. Procedure: -2. Verify Medical Doctor order. The order should state the CPAP pressure. -14. Equipment cleaning: a. Daily: Place the CPAP/ BIPAP tubing nasal mask or pillows and headgear into a sink with warm soapy water. (Use a small amount of mild dish detergent). Agitate these supplies in the water for approximately 5 minutes. Rinse well with warm water and allow to dry until all moisture is gone. -15. Disposable equipment: -a. CPAP/ BIPAP tubing; change every 30 days or when soiled and unable to be properly cleaned. -16. If a patient is admitted to the facility with existing equipment, the nurse should contact RT (respiratory therapist) for instruction. -17. Patient should be allowed to use their own equipment. The facility should obtain all necessary paperwork and instructions to manage. 1. Resident #10 was admitted to the facility in April 2022 with diagnoses that include chronic obstructive pulmonary disease (COPD), asthma, chronic respiratory failure with hypoxia (low oxygen levels), and anxiety disorder. Review of Resident #10's most recent Minimum Data Set (MDS) Assessment, dated 6/25/24, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating that Resident #10 has moderate cognitive impairment. The MDS further indicated that Resident #10 utilizes continuous oxygen therapy. During the survey the surveyor made the following observations: -On 7/23/24 at 7:53 A.M. and 10:05 A.M., Resident #10 was observed in his/her room sitting up in his/her wheelchair. The Resident was not utilizing oxygen. An oxygen concentrator was observed in the room, in the off position and without oxygen tubing attached. -On 7/24/24 at 3:17 A.M., Resident #10 was observed sitting up in their wheelchair and awake. The Resident was not utilizing oxygen. An oxygen concentrator was observed in the room, in the off position and without oxygen tubing attached. -On 7/24/24 at 7:42 A.M., Resident #10 was observed lying in bed, awake. The Resident was not utilizing oxygen. An oxygen concentrator was observed in the room, in the off position and without oxygen tubing attached. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/25/24 at 7:11 A.M., Resident #10 was observed sleeping in bed. The Resident was not utilizing oxygen. An oxygen concentrator was observed in the room, in the off position and without oxygen tubing applied. -On 7/25/24 at 10:51 A.M., Resident #10 was observed sitting up in their wheelchair. The Resident was not utilizing oxygen. An oxygen concentrator was observed in the room, in the off position and without oxygen tubing applied. Review of Resident #10's active respiratory plan of care, dated 12/1/23, indicated the Resident has oxygen therapy r/t (related to) respiratory failure and to administer O2 (oxygen) as ordered. Review of Resident #10's physician's orders indicated the following: -Oxygen at 2 liters/minute via nasal cannula continuous, dated 12/1/23. Review Resident #10's July 2024 Treatment Administration Record on 7/24/24 indicated that oxygen had been administered as ordered by the physician. Further review of Resident #10's active plan of care failed to indicate that he/she refuses any care or treatments. During an interview on 7/25/24 at 1:48 P.M., Nurse #2 said if a resident has an order for continuous oxygen, it should be on the resident at all times. Nurse #2 further said that a nurse should not sign off something on the Medication or Treatment Administration Record if they are not doing it. During an interview on 7/26/24 at 11:01 A.M., the Director of Nurses said that continuous oxygen should be on the Resident at all times. She further said that staff should not be signing off on an order that they are not following through with. 2. Resident #92 was admitted to the facility in July 2023 with diagnoses that include obstructive sleep apnea, multiple sclerosis, post-traumatic stress disorder (PTSD), anxiety, and low back pain. Review of Resident #92's most recent Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. On 7/23/24 at 9:14 A.M., the surveyor observed a CPAP machine with tubing and mask attached hanging next to Resident #92's bed. Resident #92 said he/she applies and removes the CPAP him/herself and uses it every night. Review of Resident #92's active physician's orders on 7/26/24, failed to indicate an order for the use of CPAP. Review of Resident #92's active care plan on 7/26/24, failed to indicate a plan of care for the use of CPAP or the management of obstructive sleep apnea. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 7:23 A.M., Nurse #12 said that he works overnight and takes care of Resident #92. Nurse #12 said that the Resident uses CPAP and usually manages it him/herself. Nurse #12 said that he checks in on the Resident at night. Nurse #12 said that there is not a physician's order for the use of CPAP but there should be one. During an interview on 7/25/24 at 11:02 A.M., the Director of Nurses said there should be physician's orders in place for the use of CPAP. 48990 3. Resident #106 was admitted to the facility in May 2024 with diagnoses including obstructive sleep apnea and congestive heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/5/24, indicated that Resident #106 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS also indicated Resident #106 did not use CPAP in the last 14 days. On 7/23/24 at 8:43 A.M., the surveyor observed Resident #106 in bed with a CPAP machine on his/her bedside table. The CPAP machine and undated tubing was visibly soiled with a buildup of grime. Resident #106 said he/she had only been able to use it four times since coming to the facility in May because nobody helped clean the machine, but he/she would like to use it because he/she has sleep apnea and has trouble breathing at times. On 7/24/24 at 3:24 A.M., Resident #106 awake and was sitting up in bed, not wearing CPAP mask. The CPAP machine was on his/her bedside table. The CPAP machine and undated tubing was visibly soiled with a buildup of grime. Resident said he/she kept waking up unable to catch his/her breath but could breathe now that he/she was awake and sitting up in bed. Resident #106 said he/she couldn't use his/her CPAP because nobody helped clean the machine and it's too hard to clean it by him/herself. On 7/25/24 at 7:59 A.M., Resident #106 was observed lying flat sideways in bed, not wearing the CPAP mask. The CPAP machine was on his/her bedside table. The CPAP machine and undated tubing was visibly soiled with a buildup of grime. Resident #106 was abruptly twitching and shaking and required Nurse #14 and a certified nurse assistant (CNA) assistance to help reposition and elevate Resident #106's head of bed. Nurse #14 said she did not know if Resident #106 had shortness of breath when lying flat. Nurse #14 said Resident #106 had the CPAP in his/her room since admission in May. Resident #106 said to Nurse #14 he/she had wanted to wear it but couldn't because he/she needs it cleaned. Review of Resident #106's physician's progress notes, dated 5/31/24, 6/3/24, 6/5/24, 6/7/24, 6/11/24, 6/14/24, 6/17/24, 6/20/24, 6/21/24, 6/28/24, 7/1/24, 7/2/24, 7/19/24, 7/22/24, and 7/23/24, indicated: - OSA (obstructive sleep apnea): continue with CPAP at night. Review of Resident #106's active physician's orders failed to indicate orders for respiratory care or CPAP. Review of Resident #106's entire plan of care failed to address any respiratory care or CPAP. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #88's entire medical record failed to indicate Resident #106 had refused to utilize CPAP machine. During an interview on 7/25/24 at 8:04 A.M., Nurse #14 said Resident #106 should have an order and care plan for his/her CPAP machine to ensure the care necessary is provided for its use, such as cleaning. Nurse #14 said staff are responsible for ensuring CPAP machines are cleaned and cared for, and it would never be the responsibility of Resident #106. Nurse #14 said she would have expected nursing to obtain an order or document refusal for CPAP when it was noted to be present on his/her bedside on admission in May. During an interview on 7/25/24 at 8:10 A.M., Certified Nurse Assistant (CNA) #4 said she is usually scheduled 6 A.M. -2 P.M. and had seen the CPAP machine on his/her bedside since he/she was admitted in May. CNA #4 said she had never seen Resident #106 wearing a CPAP machine when he/she was sleeping and had never offered to clean it. During an interview on 7/26/24 at 10:02 A.M., the Director of Nursing (DON) said a physician's order is required for CPAP use. The DON said when Resident #106 was admitted with his/her CPAP machine a physician's order should have been obtained for its use. The DON said if Resident #106 had refused to use the CPAP, that would be expected to be documented. The DON said a resident would never be responsible for cleaning their own CPAP, and if Resident #106 had requested to clean it him/herself that should be documented, or care planned but was not. 4. Resident #58 was admitted to the facility in October 2023 with diagnoses including asthma and obstructive sleep apnea. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #58 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS also indicated Resident #58 did not receive oxygen therapy. Review of Resident #58's active physician's orders failed to indicate a physician's order for oxygen administration. Review of Resident #58's plan of care related to respiratory, revised 5/6/24, indicated: - Administer respiratory treatments per physician's (MD) orders. On 7/23/24 at 8:49 A.M., the surveyor observed Resident #58 in bed with a nasal cannula in his/her nostrils with tubing connected to an oxygen concentrator with settings reading oxygen was being delivered at 3 liters per minute (lpm). The oxygen tubing was undated. Resident #58 said the nurses don't change the tubing very often. The surveyor made the following additional observations: - On 7/24/24 at 3:39 A.M., Resident #58 was observed in bed wearing a nasal cannula with undated tubing connected to an oxygen concentrator with settings reading oxygen was being delivered at 3 lpm. Resident reported shortness of breath and requests his/her inhaler. The surveyor immediately notified Nurse #12. Nurse #12 said Resident #58 frequently has difficulty breathing in the morning because of asthma and brought Resident #58 his/her inhaler. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 7/24/24 at 7:18 A.M., Resident #58 was observed in bed wearing a nasal cannula with undated tubing connected to an oxygen concentrator with settings reading oxygen was being delivered at 3 lpm. Resident #58 said his/her breathing is better since getting his/her inhaler earlier. Review of Resident #58's vital signs summary report indicated Resident #58 received oxygen on 7/4/24, 7/6/24, 7/7/24, 7/11/24, 7/12/24, 7/13/24, 7/14/24, 7/15/24, 7/16/24, and 7/24/24. During an interview on 7/24/24 at 9:02 A.M., Certified Nurse Assistant (CNA) #3 said Resident #58 had been receiving oxygen since he/she was admitted in October 2023. During an interview on 7/24/24 at 10:18 A.M., Nurse #14 said a physician's order is required for oxygen use prior to oxygen administration, except in emergencies. Nurse #14 said Resident #58 has received oxygen for at least a month, if not longer, and is not being used on an emergency basis. Nurse #14 said Resident #58 does not have a physician's order for oxygen administration but should. Nurse #14 said oxygen tubing should always be dated. During an interview on 7/24/24 at 10:33 A.M., The Director of Nursing (DON) said a physician's order is required for oxygen administration. The DON said if oxygen was applied during an emergent situation, a physician's order should be obtained as soon as practicable. The DON said oxygen tubing should always be dated and changed weekly. The DON said Resident #58 should have a physician's order for oxygen administration because it's not for an emergency. 44095 5. Resident #13 was admitted to the facility in April 2024 with diagnoses including asthma, obstructive sleep apnea, schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/18/24, indicated that Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 and he/she required oxygen. On 7/23/24 at 8:06 A.M., the surveyor observed Resident #13 in his/her bed, he/she was wearing oxygen at 8 liters per minute (LPM) via nasal canula. Resident #13 said he/she does not adjust his/her own oxygen settings. On 7/23/24 at 9:54 A.M., 7/24/24 at 3:05 A.M., 7/24/24 at 7:24 A.M., 7/24/24 at 8:57 A.M., 7/24/24 at 10:03 A.M., 7/25/24 at 6:40 A.M., 7/25/24 at 8:34 A.M., 7/25/24 at 12:49 P.M., 7/25/24 at 4:01 P.M., 7/26/24 at 6:52 A.M., 7/26/24 at 12:11 P.M., and on 7/29/24 at 6:55 A.M., the surveyor observed Resident #13 wearing oxygen at 8 liters per minute (LPM) via nasal canula. Review of Resident #13's plan of care related to respiratory, dated 4/12/24, indicated: - administer oxygen as per physician's order. Review of Resident #13's physician's order, dated 4/22/24, indicated: - O2 at 6 liters/min via nasal canula (n/c) continuous, every shift (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's social service note, dated 6/26/24, indicated the following: - it was discussed that oxygen (O2) levels have decreased from 8 liters to 6 liters - but this seems to be the new baseline. During an interview on 7/29/24 at 7:10 A.M., Nurse #11 said that Resident #13 requires continuous oxygen and his/her physician's order is for 6 LPM. Nurse #11 said that she verifies the oxygen setting each shift. On 7/29/24 at 11:47 A.M., the surveyor and Nurse #8 observed Resident #13's oxygen set to 8 LPM. Nurse #8 said that the physician's order is for 6 LPM. During an interview on 8/1/24 at 4:11 P.M., Nurse #13 said that Resident #13 requires continuous oxygen at 6 LPM. Nurse #13 said he is not aware of Resident #13 adjusting his/her own oxygen setting. During an interview on 7/29/24 at 4:28 P.M., the Director of Nursing said that nursing should implement the physician's order and set Resident #13's oxygen to the correct setting. 50338 6. Resident #48 was admitted to the facility in October 2022 with diagnoses including chronic respiratory failure with hypoxia, interstitial lung disease, diabetes, and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 7/12/24, indicated Resident #48 had a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15 which indicated moderate cognitive impairment. The MDS further indicated that Resident #48 utilizes oxygen therapy. During the survey the surveyor made the following observations: -On 7/23/24 at 7:45 A.M., Resident #48 was observed in his/her room lying in bed awake. An oxygen concentrator was observed in his/her room, oxygen was set at three liters per minute and was being delivered to Resident via nasal cannula. -On 7/24/24 at 3:49 A.M., Resident #48 was observed in his/her room lying in bed asleep. An oxygen concentrator was observed in his/her room, oxygen was set at three liters per minute and was being delivered to Resident via nasal cannula. -On 7/24/24 at 8:20 A.M., Resident #48 was observed in his/her room lying in bed awake. An oxygen concentrator was observed in his/her room, oxygen was set at three liters per minute and was being delivered to Resident via nasal cannula. -On 7/25/24 at 7:02 A.M., Resident #48 was observed in his/her room lying in bed awake. An oxygen concentrator was observed in his/her room, oxygen was set at three liters per minute and was being delivered to Resident via nasal cannula. Review of Resident #48's active respiratory plan of care, dated 1/15/24, indicated the Resident had oxygen therapy r/t (related to) respiratory failure with hypoxia and to use O2 (oxygen) at four liters per minute. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #48's physician's order indicated the following: -administer oxygen via nasal cannula at four to ten liters. Check oxygen saturation every shift, dated 1/21/24. Review Resident #48's July 2024 Medication Administration Record (MAR) indicated that oxygen had been administered as ordered by the physician. Review of Resident #48's Nurse Practitioner #1 (NP) progress note, dated 6/19/24, indicated Resident continued two liters of oxygen via nasal cannula. Review of Resident #48's NP #1 progress note dated, 6/24/24, indicated Resident's oxygen saturation was stable at 2.5 liters via nasal cannula. Review of Resident #48's nurse progress note, dated 6/29/24, indicated Resident continued oxygen three liters via nasal cannula. Review of Resident #48's NP #1 progress note, dated 7/12/24, indicated Resident continued oxygen 2.5 liters of oxygen via nasal cannula. Review of Resident #48's Physician #1 progress note, dated 7/13/24, indicated Resident was on two liters of oxygen via nasal cannula. Review of Resident #48's NP #1 progress note, dated 7/17/24, indicated Resident continued 2.5 to 3 liters of oxygen via nasal cannula. Review of Resident #48's NP #1 progress note, dated 7/25/24, indicated Resident's family member requested for patient to be evaluated as her oxygen was increased from two liters to four liters. During an interview on 7/29/24 at 7:08 A.M., Nurse #8 said Resident #48's oxygen order is two to ten liters. Nurse #8 and surveyor reviewed Resident #48's oxygen order and Nurse #8 said that the order indicated four-ten liters. Nurse #8 said Resident would not be able to reach oxygen to adjust on his/her own. During an interview on 7/31/24 at 11:50 A.M., Director of Nursing (DON), said the physician orders for oxygen setting should be followed by nursing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on interview and record review, the facility failed to ensure that pain management, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences was provided for two Residents out of a total sample of 39 residents. Specifically: 1) For Resident #85, the facility failed to utilize as-needed (PRN) pain medication for breakthrough pain and wound dressing changes as directed by the physician. 2) For Resident #75, the facility failed to ensure nursing provided pain management in accordance with professional standards of practices. Specifically for Resident #75 the facility failed consistently administer his/her physician's ordered pain medication on time. Findings include: Review of the facility policy, titled Pain Management, revised in October 2022, indicated, but was not limited to, the following: - The facility is committed to reducing physical and psychosocial symptoms associated with pain to assist the resident in achieving their highest practicable level of functioning. - The facility promotes resident self-reporting as the most reliable indicator of pain. Facility clinicians use objective pain scales when caring for residents that are able to assist in determining the severity of pain and effectiveness of interventions. Residents with a cognitive impairment will be assessed for pain based on objective clinical evaluation using the PAINAD pain scale (a tool used to assess pain in people with dementia by observing five behaviors: Breathing, Negative vocalization, Facial expression, Body language, Consolability.) Procedure: - Review interdisciplinary assessments and documentation. - Identify potential causes for resident pain. Evaluate alleviating and/or exacerbating factors. Review effectiveness of past and current treatment. - Determine appropriate interventions to manage pain and side effects. Appropriate interventions may include pharmacologic as well as non-pharmacologic interventions. - Develop and revise the resident's plan of care. - Communicate interventions to staff. - Evaluate effectiveness of pain management intervention(s) within 30-60 minutes. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	- Notify the physician if interventions are not effective in achieving resident comfort and/or functional goals. - Re-assess resident status indicated including, but not limited to: - o Level of pain relief - o Side effect management - o Effectiveness of interventions - o Need for increasing/decreasing amount of medication due to tolerance or side effects. - Review and revise plan of care as necessary. 1. Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #85 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 was at risk for developing pressure ulcers and that the Resident had an unhealed Stage IV pressure ulcer. Review of the MDS also indicated that the Resident had not received PRN pain medications or non-medication interventions for pain. Review of Resident #85's Pain care plan, initiated 3/8/23, indicated the Resident had an alteration in comfort related to chronic pain and existing pressure ulcers with the following interventions: - Administer and monitor for effectiveness and for possible side effects from: Routine pain medication. - Monitor and report to nurse: sign and symptoms of pain, worsening of pain. - Pain assessment to be completed prior to initiating wound care. - Report changes in pain location/type frequency/intensity to physician. Review of Resident #85's physician's orders indicated the following active orders: - Pain evaluation Q (every) shift, use pain scale for verbal and nonverbal signs of pain, initiated 5/10/24. - Lidocaine External Patch 4%, apply to low back topically one time a day for back pain every 24 hours, initiated 3/7/23. - Morphine sulfate 100 mg/5mL (milligram/milliliters), give 0.25 mL by mouth every 4 hours as needed for pain, initiated 5/17/24. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	- Suboxone (a narcotic) sublingual film 4-1Mg, give 1 film sublingually two times a day, initiated 5/1/24. - Acetaminophen tablet 325 mg. give 2 tablets by mouth every 2 hours as needed for pain, initiated 3/7/23. - Review of Resident #85's physician's orders indicated the following discontinued orders: - Suboxone sublingual film 4-1Mg, give 1 film sublingually three times a day, initiated 4/22/24 and discontinued 4/30/24. - Sacrum - irrigate with NS (normal Saline) liquid barrier film to periwound skin, pack with 1 continue PC kerlix moistened with 1/4 Dakins change 2x/day, initiated 5/24/24 and discontinued on 7/22/24. Review of the Nurse Practitioner (NP) progress note, dated 5/13/24, indicated that Resident #85's suboxone had been gradually reduced to twice a day. Review of the Nurse Practitioner (NP) progress note, dated 5/13/24, indicated that Resident #85 was visited by palliative care who recommended to schedule morphine instead of PRN, and that the Resident continued to endorse pain in his/her sacral wound and lower back. Review Resident #85's progress note, dated 5/16/24, indicated that the Resident was seen by NP#1 for pain management. Review of the progress note indicated that the Resident had a chronic sacral decubitus ulcer and was in pain when having his/her wound vac changed. NP #1's progress note indicated that Today patient states that his/her pain is severe especially during dressing changes and that orders are in for morphine 0.25ml Q4H PRN (every four hours as needed). Will continue to monitor patient's pain while in rehab. Review of Resident #85's physician orders and Medication Administration Record (MAR) failed to indicate that morphine was ever scheduled. Review of NP #1's progress note, dated 6/14/24, indicated Resident #85 Continues to state he/she has pain at sacral area. Will continue to monitor and have patient receive morphine prior to dressing changes. Review of Resident #85's progress notes indicated that NP #1 had noted painful movement during the Residents physical examination on 5/13/24, 5/16/24, 5/22/24, 5/24/24, 5/29/24, 6/3/24, 6/13/24, 6/14/24, 6/25/24, and 7/24/24. Review of the skin only evaluation, dated 7/9/24, indicated Resident #85 was in constant pain. Review of Resident #85's vitals summary indicated the following pain readings on a 0 to 10 pain scale: - 4/23/24 at 15:12: 2 out of 10 pain. - 4/23/24 at 21:18: 3 out of 10 pain. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	- 4/25/24 at 20:28: 5 out of 10 pain. - 4/28/24 at 10:00: 10 out of 10 pain. - 5/11/24 at 12:13: 3 out of 10 pain. - 5/11/24 at 13:47: 2 out of 10 pain. - 5/31/24 at 21:43: 7 out of 10 pain. - 6/2/24 at 13:54: 4 out of 10 pain. - 6/22/24 at 12:57: 3 out of 10 pain. - 6/22/24 at 15:16: 5 out of 10 pain. - 6/25/24 at 9:57: 4 out of 10 pain. - 6/25/24 at 10:08: 5 out of 10 pain. - 6/25/24 at 13:43: 5 out of 10 pain. - 6/29/24 at 13:08: 10 out of 10 pain. Review of Resident #85's Medication Administration Record (MAR) indicated the following pain levels on a scale of 0 to 10 recorded during administration of suboxone: - 3/11/24: 3 out of 10 pain at 8 A.M., and 3 again at 10 P.M. - 3/20/24: 3 out of 10 pain at 8 A.M., and 3 again at 10 P.M. - 4/24/24: 3 out of 10 pain at 8 A.M., 3 at 2 P.M., and 3 at 8 P.M. - 4/26/24: 5 out of 10 pain at 8 A.M., 5 at 2 P.M., and 5 at 8 P.M. - 4/26/24: 10 out of 10 pain at 8 P.M. - 5/11/24: 3 out of 10 pain at 8 A.M., and 2 at 2 P.M. - 5/27/24: 3 out of 10 pain at 8 A.M., and 3 at 2 P.M. - 6/3/24: 4 out of 10 pain at 8 A.M., and 4 at 2 P.M. - 6/4/24: 4 out of 10 pain at 8 A.M., and 4 at 2 P.M. - 6/5/24: 4 out of 10 pain at 8 A.M., and 4 at 2 P.M. - 6/22/24: 3 out of 10 pain at 8 A.M., and 5 at 2 P.M. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	- 6/23/24: 5 out of 10 pain at 8 A.M., and 5 at 2 P.M. - 6/24/24: 5 out of 10 pain at 8 A.M., and 5 at 2 P.M. - 6/25/24: 5 out of 10 pain at 8 A.M., and 5 at 2 P.M. - 6/26/24: 5 out of 10 pain at 8 A.M., and 5 at 2 P.M. - 6/27/24: 10 out of 10 pain at 4 at P.M. Review of Resident #85's Treatment Administration Record (TAR) indicated that the Resident's wound dressing was changed 60 times since the NP instructed to provide morphine with dressing changes on 6/14/24. Review of the Resident #85's MAR failed to indicate that the PRN morphine was ever administered in June or July of 2024, and that the PRN morphine was only administered once in May, on 5/17/24, the day the order was initiated. Further review of the MAR failed to indicate acetaminophen was ever administered in May, June, or July. During an interview on 7/29/24 at 10:32 A.M., Resident #85 said that he/she was currently in pain, and that he/she does not feel that his/her pain medication helps. During an interview on 7/31/24 at 10:03 A.M., Certified Nursing Assistant (CNA) #11 said Resident #85 complains of pain when being repositioned. During an interview on 7/31/24 the Unit Supervisor said that if a Resident experiences breakthrough pain (a transitory flare of pain that occurs on a background of relatively well-controlled baseline pain) that nurses are expected to administer PRN pain medication. The Unit Supervisor said Resident #85 is in pain a lot of the time. During an interview on 7/31/24 at 10:14 A.M., Nurse Practitioner (NP) #1 said the goal for Resident #85 would be to decrease pain, and that if pain can't be decreased and a Resident is requesting more pain medication that the Resident would be evaluated by palliative care and the facility will follow up on palliative care recommendations. NP #1 said that the expectation was that if a Resident reports pain after his/her regularly scheduled pain medication that the nurse would administer PRN pain medication. NP #1 said that every time she has met with Resident #85 he/she had complained of pain, and that she would expect nursing to provide morphine with dressing changes and when the Resident complains of pain. 44095 2.) Resident #75 was admitted to the facility in October 2023 with diagnoses including dementia, low back pain, and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/4/24, indicated that Resident #75 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS indicated the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	Ask resident: Have you had pain or hurting at any time in the last 5 days? - Yes. Ask resident: How much of the time have you experienced pain or hurting over the last 5 days? - Almost Constantly. Ask resident: Over the past 5 days, how much of the time has pain made it hard for you to sleep at night? - Almost Constantly. Ask resident: Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain? - Almost Constantly Ask resident: Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine. (Show resident 00-10 pain scale) - 8 of 10. Review of Resident #75's plan of care related to pain, dated as revised 7/5/24, indicated the following: - Administer and monitor for effectiveness and for possible side effects from gabapentin. - Monitor and report to the nurse: signs and symptoms of pain, worsening of pain. Review of Resident #75's physician's order, dated 10/17/23, indicated: - Pain Evaluation every shift, use pain scale for verbal and nonverbal signs of pain. Review of Resident #75's physician's order, dated 10/17/23, indicated: - Gabapentin Oral Capsule 100 mg (Gabapentin), give 100 mg by mouth three times a day for chronic pain. Scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M. Review of Resident #75's physician's order, dated 2/6/24, indicated: - Baclofen Oral Tablet 10 mg (milligrams), give 10 mg by mouth three times a day related to wedge compression fracture of the second lumbar vertebra, scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M. Review of Resident #75's physician's order, dated 3/13/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	- Ibuprofen Oral Tablet 200 mg (Ibuprofen), give 2 tablets by mouth every 8 hours as needed for pain related to muscle weakness. On 7/23/24 at 10:10 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #75 including the following: - baclofen 10 mg, 1 tablet, 2 hours and 10 minutes after the scheduled time - gabapentin 100 mg, 1 capsule, 2 hours and 10 minutes after the scheduled time On 7/23/24 at 10:11 A.M., Resident #75 said he/she has 8 out of 10 pain in his/her hip and leg. On 7/23/24 at 10:12 A.M., the surveyor observed Nurse #1 prepare and administer medications to Resident #75 including the following: - ibuprofen 200 mg, 2 tablets as needed. During an interview on 7/23/24 at 10:15 A.M., Nurse #1 said she was late administering medications to Resident #75 and medications should be administered within one hour of the scheduled time. On 7/25/24 at 8:26 A.M., the surveyor was seated at the nurse's station and observed Resident #75 complaining about 8 out of 10 back pain to the Unit Supervisor. The Unit Supervisor said to Resident #75 you will have to wait until after breakfast for your medication. Review of Resident #75's Medication Administration Audit Report, dated July 2024, indicated nursing administered his/her physician's ordered 8:00 A.M. gabapentin and baclofen doses (which are scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M.) were administered after the prescribed time on the following dates and times: 7/1/24 administered at 9:24 A.M., 1 hour and 24 minutes after the scheduled time, 7/2/24 administered at 3:55 P.M., 1 hour and 55 minutes after the scheduled time, 7/3/24 administered at 12:31 P.M., 4 hours and 31 minutes after the scheduled time, 7/4/24 administered at 9:34 A.M., 1 hour and 34 minutes after the scheduled time, 7/5/24 administered at 5:27 P.M., 9 hours and 27 minutes after the scheduled time, 7/6/24 administered at 11:29 A.M., 3 hours and 29 minutes after the scheduled time, 7/8/24 administered at 10:10 A.M., 2 hours and 10 minutes after the scheduled time, 7/10/24 administered at 11:46 A.M., 3 hours and 36 minutes after the scheduled time, 7/11/24 administered at 1:35 P.M., 5 hours and 35 minutes after the scheduled time, 7/15/24 administered at 1:56 P.M., 5 hours and 56 minutes after the scheduled time, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	7/17/24 administered at 10:21 A.M., 2 hours and 21 minutes after the scheduled time, 7/19/24 administered at 9:47 A.M., 1 hour and 47 minutes after the scheduled time, 7/20/24 administered at 11:44 A.M., 3 hours and 44 minutes after the scheduled time, 7/22/24 administered at 11:43 A.M., 3 hours and 43 minutes after the scheduled time, 7/23/24 administered at 10:11 A.M., 2 hours and 11 minutes after the scheduled time, 7/24/24 administered at 9:39 A.M., 1 hour and 39 minutes after the scheduled time, 7/30/24 administered at 9:51 A.M., 1 hour and 51 minutes after the scheduled time. Review of Resident #75's Medication Administration Audit Report, dated July 2024, indicated nursing administered his/her physician's ordered 8:00 P.M. gabapentin and baclofen doses (which are scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M.) were administered after the prescribed time on the following dates and times: 7/2/24 administered at 10:16 P.M., 2 hours and 16 minutes after the scheduled time, 7/3/24 administered at 9:13 P.M., 1 hour and 13 minutes after the scheduled time, 7/6/24 administered at 9:12 P.M., 1 hour and 12 minutes after the scheduled time, 7/14/23 administered at 10:11 P.M., 2 hours and 11 minutes after the scheduled time, 7/16/24 administered at 10:23 PM., 2 hours and 23 minutes after the scheduled time, 7/23/24 administered at 9:19 P.M., 1 hour and 19 minutes after the scheduled time, 7/24/24 administered at 9:30 P.M., 1 hour and 30 minutes after the scheduled time, 7/26/24 administered at 9:41 P.M., 1 hour and 41 minutes after the scheduled time. Review of Resident #75's nurse practitioner progress note, dated 7/17/24 and 7/19/24, indicated: - chronic back pain with history of compression fracture and back spasms - has history of traumatic compression fractures as well as fractures related to falls. - currently takes gabapentin and baclofen. - M54.59 - Other low back pain: Patient has a history of traumatic compression fractures as well as fractures related to falls. He/she currently takes gabapentin 100 mg every 6 hours (Q6H) as needed (PRN) and baclofen 10 mg three times daily (TID). Patient does ambulate with walker in the long-term care facility. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0697 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #75's physician progress note, dated 7/24/24, indicated: - Patient is requesting tramadol for back pain. Family Member reports that he/she will always ask a new nurse if he/she is getting tramadol. The older nurses that know him/her tell him/her yes he/she is getting tramadol. Family Member encourages this and would like us to continue doing this with the patient as he/she gets worked up and agitated when he/she finds that he/she is not getting tramadol. There is a new nurse today who referred him/her to me. Did review the patient's medications with the Family Member and appears that he/she is on 2 different muscle relaxers. I will stop the baclofen at this. Patient has had behavior agitation past related to his/her dementia but none currently. On exam patient is able to bend and back without problem able to bend his right leg without problem. No objective signs of pain. [sic] During an interview on 7/29/24 at 4:40 P.M., the Director of Nursing (DON) said medications should be administered within one hour of the scheduled times and pain management medications should be given on time.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49880 Based on record review and interview the facility failed to ensure services consistent with professional standards were provided for two Residents (#22 and #65) who required dialysis (a procedure to remove waste products and excess fluid from the body when the kidneys stop working properly), out of total sample of 39 residents. Specifically, the facility failed to follow physician's orders to ensure that blood pressure readings were not taken on the arm where the dialysis shunt (an access point from the dialysis machine to a blood artery) is located. Findings include: Review of facility policy titled Dialysis Management, dated as revised 10/2022, indicated the following: -Policy: Residents receiving hemodialysis treatments will be assessed and monitored to ensure quality of life and well-being. -Procedure: 2. The nurse will obtain orders for monitoring of site, and interventions as appropriate. Orders to include: no blood work or blood pressure in arm with shunt. 1. Resident #22 was admitted to the facility in September 2022 with diagnoses that include type 2 diabetes, chronic kidney disease stage 5, insomnia, and post traumatic stress disorder (PTSD). Review of Resident #22 most recent Minimum Data Set (MDS) Assessment, dated 5/10/24, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15, indicating that the Resident has moderate cognitive impairment. The MDS further indicates that Resident #22 receives dialysis. On 7/23/24 at 9:35 A.M., Resident #22 was observed in bed. He/she said that they receive dialysis. An external catheter was observed, covered, on Resident #22's right chest wall. Resident #22 said they also have a fistula in the right arm that is not currently being used at dialysis. Review of Resident #22's active physician orders indicated the following: - No Blood Pressure to be taken in the L arm due to stenosis, dated 9/13/22. - Monitor right chest dialysis catheter every shift, dated 8/5/23. - AV (arteriovenous) Right chest Fistula/AV Graft: Monitor for Bruit and thrill every shift and notify physician for absence. Monitor for bleeding, if noted, apply pressure, and notify physician. No B/P [blood pressure] in Right arm, dated 8/29/23. [sic] -No blood pressure or blood draw on the right arm due to dialysis access site, dated 12/8/23. Review of Resident #22's active hemodialysis care plan, dated as initiated on 2/7/24 indicated the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No BP on limb with shunt/ CV (central venous) dialysis catheter. Review of blood pressure readings in Resident #22's medical record indicated that staff obtained blood pressures on the left arm thirty-one times in June 2024 and twenty-three times in July 2024 and on the right arm six times in June 2024 and two times in July 2024 During an interview on 7/26/24 at 10:42 A.M., Unit Supervisor said that Resident #22 should have his/her blood pressures obtained on the legs due to the order for no blood pressures to either the left or right arm. Unit Supervisor and surveyor reviewed blood pressure results in the medical record, and he said based on documentation, nurses are using both the left and right arm to obtain a blood pressure. During an interview on 7/26/24 at 10:55 A.M., the Director of Nurses said that nurses should obtain blood pressure readings in accordance with physician orders and the Resident's plan of care and staff are not. 44095 2.) Resident #62 was admitted to the facility in February 2024 with diagnoses including chronic kidney disease, diabetes, depression, and obesity. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/8/24, indicated that Resident #62 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #62 required dialysis. Review of Resident #62's physician's order, dated 7/4/24, indicated: - Resident to attend dialysis 3 times a week on Tuesday, Thursday, and Saturday. Review of Resident #62's plan of care related to hemodialysis, dated 7/12/24, indicated: - Coordinate resident's care in collaboration with dialysis center. - Protect access site from injury. Site: right chest, avoid constriction on affected arm, such as carrying purse and constrictive clothing. - No blood pressure (BP) on right (R) limb with shunt/central venous (CV) dialysis catheter. Review of Resident #62's weights and vitals tab on 7/25/24, indicated the following. Between 7/12/24 to 7/25/24 nursing obtained his/her blood pressure from the right arm 13 times, 3 of which were obtained by Nurse #10. During an interview on 7/25/24 at 3:59 P.M., Resident #62 said that nursing staff obtains his/her blood pressures on both his/her left and right arms. Resident #62 said that staff should not obtain blood pressure in his/her right arm. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/24 at 7:12 A.M., Nurse #11 said no vitals should be obtained on the side with the catheter. During an interview on 7/25/24 at 4:10 P.M., Nurse #10 said she shouldn't obtain blood pressures on Resident #62's right arm. Review of the weights and vitals summary indicated Nurse #10 has obtained Resident #62's blood pressures 3 times on his/her right arm between 7/12/24 to 7/25/24. During an interview on 7/29/24 at 4:14 P.M., the Director of Nursing said nursing should follow the plan of care and not obtain blood pressures on Resident #62's right arm.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 Based on record review and interview the facility failed to ensure a plan of care was developed for Trauma-Informed Care for four Residents (#13, #83, and #35), who were admitted with the diagnosis of Post-Traumatic Stress Disorder (PTSD) out of a total sample of 42 residents. Specifically, 1. For Resident #13, who was assessed by nursing as a trauma survivor, the facility failed to develop a plan of care accounting for Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the Resident. 2. For Resident #83 the facility failed to develop a plan of care for trauma-informed care related to a diagnosis of PTSD. 3. For Resident #35 the facility failed to develop a plan of care for trauma-informed care related to a diagnosis of PTSD. Findings Include: Review of facility policy titled Trauma Informed Care, dated as revised [DATE], indicated the following: -It is the policy of the facility to ensure that residents who are trauma survivors receive culturally competent trauma-informed care in accordance with professional standards of practice which are culturally competent and account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatizations. -Care Planning -1. the facility should collaborate with resident trauma survives, and as appropriate, the resident's family, friends and other healthcare professionals (such as psychologists, mental health professionals) to develop and implement individual interventions. -3. Care plans should have interventions that minimize or eliminate the effect of known triggers a. if triggers are unknown/ unreported facility should multiple ways to identify resident triggers. [sic] 4. Trigger-specific interventions should identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. 1. Resident #13 was admitted to the facility in [DATE] with diagnoses including asthma, obstructive sleep apnea, schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 and had Post Traumatic Stress Disorder (PTSD). Review of Resident #13's N Adv - Clinical Admission - V 16, dated [DATE], indicated: Say to Resident: Sometimes things happen to people that are traumatic (Examples: war; abuse [physical, psychological, or sexual] a natural disaster, or a loved one that died a traumatic death) 1. Have you faced a traumatic event or experience in the past? Yes 2. Recently, have you thought about the events) or experiences when you did not want to? Yes Review of Resident #13's plan of care related to behaviors and PTSD, dated [DATE], failed to include an individualized plan of care accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Review of Resident #13's psychiatric evaluation and consultation note, dated [DATE], indicated: - PTSD. During an interview on [DATE] at 8:50 A.M., Certified Nurse Assistant (CNA) #5 said Resident #13 had behaviors, but she is not sure about any past trauma. During an interview on [DATE] at 8:45 A.M., Nurse #7 said Resident #13 had behaviors, but she is not sure about any past trauma. During an interview on [DATE] at 4:10 P.M., Nurse #13 said that he admitted Resident #13 and completed the nursing admission assessment. Nurse #13 said that Resident #13 said that he/she had past trauma, and it was the social workers responsibility to develop a plan of care for PTSD. During an interview on [DATE] at 9:08 A.M., the MDS Nurse said the Social Worker is responsible for developing a PTSD care plan. During an interview on [DATE] at 10:55 A.M., the Social Worker said that if a resident has a diagnosis of PTSD then he makes a referral to psychiatric services for an evaluation. He said that he does not initiate a care plan unless recommendations are made by psychiatric services to follow in regard to the diagnosis. He further said we depend on psychiatric services to let us know appropriate approaches for each resident. During an interview on [DATE] at 11:36 A.M., the Director of Nursing said Resident #13 needs a comprehensive care plan for PTSD. 49880 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #83 was admitted to the facility in [DATE] with diagnoses that include alcohol abuse, post-traumatic stress disorder (PTSD) and type 2 diabetes. Review of Resident #83's most recent Minimum Data Set (MDS) Assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15 indicating that the Resident is cognitively intact. The MDS further indicated a diagnosis of PTSD. Review of Resident #83's medical record indicated an active diagnosis of PTSD dated as added [DATE]. Review of a Psychiatric Evaluation and Consultation note, dated [DATE], indicates an active diagnosis of PTSD. Review of Resident #83's active care plan failed to indicate a plan of care for Trauma- Informed Care related to his/her diagnosis of PTSD. During an interview on [DATE] at 10:55 A.M., Social Worker #1 said that if a resident has a diagnosis of PTSD then he makes a referral to psychiatric services for an evaluation. He said that he does not initiate a care plan unless recommendations are made by psychiatric services to follow in regard to the diagnosis. He further said the facility depends on psychiatric services to let us know appropriate approaches for each resident. During an interview on [DATE] at 10:48 A.M., the Director of Nurses (DON) said that every resident with a diagnosis of PTSD should have a plan of care in place addressing the diagnosis. She further said that the care plan should be patient specific and address resident triggers depending on the origin of the diagnosis. 50338 3.) Resident #35 was admitted to the facility in February 2024 with diagnoses including a stroke affecting left side, diabetes, and post-traumatic stress disorder (PTSD). Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #35 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Review of Resident #35's hospital discharge summary, dated [DATE], indicated a diagnosis of PTSD, anxiety, and depression and recommended to continue Buspar 20 mg (milligrams) three times per day and Sertraline (antidepressant) 25 milligrams (mg) daily. He/she stated several times I just need peace and quiet at home. The hospital discharge summary indicated during Resident #35's visit to hospital his/her family member was intoxicated and there was a verbal altercation between the family member and the staff that lead to the family member being removed by security and he/she was brought to the emergency room . At that time, Resident #35 said he/she did not feel his/her family member can take care of him/her. The family member drinks and has days when he/she is angry, although never violent. Resident #35 said the family member has never hit him/her but is afraid that he/she will smash his/her belongings. Review of nursing clinical assessment, dated [DATE], indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Trauma Informed Care 2. Have you faced a traumatic event or experience in the past? a. Yes 3. Recently, have you thought about the event(s) or experience when you did not want to? a. Yes 4. Have you had poor sleep, poor concentration, jumpiness, irritability, or feeling watchful because of the event or experience? a. Yes Review of Resident #35's social service assessment, dated [DATE], indicated that the Resident does not report, and the medical record does not reflect, a history of trauma and/or PTSD. The social service assessment indicated a concern from resident and family that returning home may not be safe and that alcohol use with problematic behaviors is documented with Resident #35's family member. Review of Resident #35's initial and psychiatric evaluation and consultation, dated [DATE], indicated that Resident #35 has a diagnosis of PTSD and that he/she lives with family member who drinks. The Psychiatric evaluation recommended resident would benefit from continued behavioral health. Review of the entire plan of care failed to indicate a plan of care related to PTSD. During an interview with Resident #35 on [DATE] at 9:30 A.M., said he/she would like to see a social worker because he/she was worried about losing his/her housing and his/her family member was currently living there, but he/she can't take care of him/her anymore. During an interview on [DATE] at 7:53 A.M., Nurse #8 said she was not aware that Resident #35 had diagnosis of PTSD. Nurse #8 said if Resident #35 had a diagnosis of PTSD there should be a care plan to make staff aware of triggers and care required. During an interview on [DATE] at 2:05 P.M., the Social Worker said he reviews hospital discharge summaries for all new admissions. During review, if he sees that a resident has a diagnosis of PTSD, he refers the resident to psychiatric services for an assessment. The Social Worker completes his own assessment of the resident and interviews the resident to discuss PTSD. The Social Worker said the resident should have a care plan to address PTSD even if not aware of any triggers, but just so that staff is aware of the potential. The Social Worker said he must have overlooked Resident #35's diagnosis of PTSD in his/her discharge summary and was not aware that Resident #35 had a diagnosis of PTSD. The Social Worker said there should be a care plan in place, and he would have implemented it if he had known he/she had a diagnosis of PTSD. During an interview on [DATE] at 9:08 A.M., the MDS Nurse said that since Resident #35 had a diagnosis of PTSD then the Social Worker should have implemented a PTSD care plan but did not. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:46 A.M., the Director of Nursing (DON) said that any resident admitted with PTSD should be assessed by the Social Worker and a PTSD care plan should be implemented and include underlying causes, triggers and behaviors associated with PTSD.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 49880 Based on observations, record review and interviews, the facility failed to assess one Resident (#103) for the use of side rails. Specifically, the facility failed to assess the risk of entrapment from side rails, review the risks and benefits of side rails and obtain informed consent from the resident prior to installation of side rails. Findings Include: Review of facility policy, titled Side Rails, undated, indicated the following: -Each resident will be assessed for functional status on admission, readmission, quarterly, for any significant change and as needed. Side rails will only be used by a resident to assist with his or her bed mobility. -Side rails will be analyzed for safety and prevention of entrapment. -5. the staff shall obtain consent for the use of side rails/ enabler form the resident or the resident's legal representative prior to their use. 6. Resident's that require the use of side rails will obtain an order from the MD indicating that side rails are used to assist with bed mobility. 7. The use of side rails for bed mobility will be documented in the resident's comprehensive care plan. 10. The following areas of entrapment will be checked when the bed is in the flat position and the partial rails are in the upright: -Zone #1 Open space within the rail. Open Spaces within the rail will not exceed more than 4 3/4 inches/ 120 mm (millimeters). Resident #103 was admitted to the facility in March 2024 with diagnoses that include type 2 diabetes, stage 4 sacral ulcer, post herpetic trigeminal neuralgia and syncope and collapse. Review of Resident #103's most recent Minimum Data Set (MDS) Assessment, dated 6/21/24, indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15, indicating that the resident has moderate cognitive impairment. On 7/24/24 at 8:42 A.M., the surveyor observed Resident #103 lying in bed, bilateral side rails in place and in the up position. On 7/25/24 at 7:43 A.M., the surveyor observed Resident #103 lying in bed awake, bilateral side rails in place and in the up position. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's progress notes, dated 6/13/24, that indicated: -Around 5:30 P.M. a nursing assistant called for help. I went to the room and found the patient with his/her right arm stuck inside the side rails of her bed. I called the staff to assist in freeing his/her arm. There were no injuries or bruises. We will continue to monitor the situation. [sic] Review of Resident #103's medical record failed to indicate a consent for the use of side rails. Review of Resident #103's physician orders failed to indicate an order for the use of side rails. Review of Resident #103's active care plan failed to indicate the use of side rails. Review of Resident #103's evaluation history failed to indicate a side rail assessment was completed prior to the installation and use of side rails. Review of Resident #103's paper record on 7/25/24, indicated a blank assessment form titled side rail/ bed rail evaluation. During an interview on 7/26/24 at 8:14 A.M., Nurse #2 said that when a resident is admitted to the facility an assessment should be completed by nursing to determine if a resident is safe to use side rails on their bed. Nurse #2 further said that a consent should be signed by the resident or resident representative consenting to the use of side rails. She also said that a resident should have a physician's order in place for the use of side rails. She said she was the nurse taking care of Resident #103 on 6/13/24 when he/she got their arm stuck in the side rail of the bed. She said there was no injury and that the use of side rails was not reassessed after the incident. She said that a side rail assessment should have been done after the incident to ensure the resident was safe, but it was not. During an interview on 7/25/24 at 11:15 A.M., the Director of Nurses (DON) said she was made aware of the incident involving Resident #103 getting their arm stuck in the side rail of the bed. The DON said that on admission to the facility Resident #103 should have been assessed for the use of side rails, signed consent for the use of side rails, and had a physician's order for the use of side rails. She further said that the Resident should have been reassessed for the continued use of side rails after the incident on 6/13/24.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on interviews, record review, staff education and Facility Assessment review, the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically: 1.) The facility failed to ensure licensed nursing staff were trained and demonstrated competency related to wound care, treatment administration, transcribing orders, pressure ulcer prevention, change in condition, and communication. For Resident #85, the facility failed to implement treatments and physician orders recommended by the consulting wound physician resulting in a new necrotic skin condition progressing to an unstageable wound leading to osteomyelitis (a bone infection) and sepsis (a life-threatening response to infection) requiring hospitalization and need for a fecal-diverting colostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, that allows digested food to pass out of the body through an external pouch system). 2.) The facility failed to ensure that the nursing staff received the appropriate competencies and skill sets necessary for the care and treatment of residents. Specifically, the facility failed to ensure competencies were completed and documented for 5 out of 5 certified nursing assistants (CNAs), and 12 out of 12 licensed nurses whose education records were reviewed. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 1.) Review of the facility policy titled Ulcer/skin Breakdown Clinical Protocol, created January 2023, indicated, but was not limited to, the following: - All caregivers are responsible for preventing, care of, and providing treatment for Skin Ulcerations. Review of the Facility Assessment Tool, dated 5/24/24, included but was not limited to the following: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Commonly admitted diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management: Integumentary System (the body system consisting of skin, hair, nails and glands): Skin Ulcers, Injuries, surgical wounds. Facility utilizes Wound Physicians: MD (medical doctor)/NP (nurse practitioner), Nursing, Registered Dietician, Regularly scheduled skin Assessments, Wound care supplies, Consultation with specialist as needed for wound management. - Services and Care we Offer based on our Resident's Needs: Skin Integrity: Pressure injury prevention and care, skin care, wound care, (surgical, other skin wounds). - Staff training/education and competencies: Competencies by department. - Licensed Nurses Competencies on hire and PRN (as needed): Skin Prevention/Wound Program, Transcribing order, Change in Condition, Communication - Licensed Nurses Annual Competencies: Treatment Administration - Certified Nurse Assistant (CNA) Annual Competencies: Preventative skin care. During a tour of the facility on 7/23/24 at 8:11 A.M., the surveyor interviewed residents and the following statements regarding staff competencies were reported: - One resident on the [NAME] Unit said, I'm concerned my nurses weren't trained to care for my wounds. - Another resident on the [NAME] Unit said, sometimes my wound dressing isn't changed every day like it should be because the nurses said they don't know how. Throughout the Recertification Survey (7/23/24 through 7/26/24 and 7/29/24 through 8/1/24) the surveyors identified multiple concerns regarding the repeated failure to implement wound care recommendations, notify the physician of wound care recommendations, and failure to transcribe the physician's orders related to wound care. For Resident #85, the facility failed to implement treatments and physician orders recommended by the consulting wound physician resulting in a new necrotic skin condition progressing to an unstageable wound leading to osteomyelitis (a bone infection) and sepsis (a life-threatening response to infection) requiring hospitalization and need for a fecal-diverting colostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, that allows digested food to pass out of the body through an external pouch system). Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's Skin Only Evaluation, dated 3/11/24, indicated Resident #85 had a new necrotic (the death of body tissue or an organ due to a lack of blood supply) wound on the left buttock, medial area, and that the wound did not have an odor. Review of Resident #85's initial Wound Evaluation and Management Summary, dated 3/12/24, indicated the Wound Physician evaluated the Resident for a rash. The Wound Physician diagnosed Resident #85 with diaper dermatitis and recommended lotrisone cream (an anti-fungal cream) to be applied twice daily to the affected area and prn (as needed). Review of Resident #85's Treatment Administration Records failed to indicate that the lotrisone cream was implemented. During an interview on 7/29/24 at 10:03 A.M., Nurse #17 said that when changes in skin are identified they should be reported to the NP (Nurse Practitioner)/MD (medical doctor). Nurse #17 said she had not reported the wound to the physician because the wound did not need the physicians' attention because of how small it was. Nurse #17 said aides had been using house barrier cream to Resident #85 buttocks region, which was not a new treatment for the newly identified wound in March. During an interview on 7/30/24 at 11:13 A.M., The Wound Physician said she was initially consulted on 3/12/24 to evaluate a rash on Resident #85's frontal groin area, and nothing else; as the rash was on the front she may not have evaluated the backside and she was not aware of a necrotic wound when she evaluated the rash. The Wound Physician said this may have been a result of bad communication. Review of Resident #85's entire medical record indicated a wound treatment was not ordered until 3/23/24, 12 days after Nurse #17 had initially identified the necrotic wound. Following this initial failure to notify the physician of the change in condition (the new necrotic skin condition), failure to implement wound care recommendations for a skin condition, failure to notify the physician of the wound care recommendations, and failure to transcribe the physician's orders related to wound care, there continued to be repeated failures, including, but not limited to: - On 3/26/24, the Wound Physician recommended alginate calcium (a gel that promotes wound healing), or santyl (an ointment used to promote the healing of skin ulcers by removing damaged tissue) for Resident #85's unstageable sacral ulcer, which was first identified by nursing on 3/11/24. The physician's orders for alginate calcium and santyl were never implemented before Resident #85 was emergently hospitalized on [DATE]. Review of Resident #85's hospital discharge summary indicated he/she was admitted with a diagnosis of sepsis with the presumed source of the infected sacral ulcer. During this hospitalization, the status of the sacral ulcer, with osteomyelitis, necessitated the creation of a fecal-diverting colostomy. - On 3/26/24, the Wound Physician recommended a house supplement (a calorically and nutritionally fortified drink typically utilized to address weight loss and/or meet assist in meeting nutrient, such as protein, needs). This house supplement was never implemented. - On 4/23/24, the Wound Physician recommended a negative pressure wound therapy (NPWT) to be applied and to be changed three times per week for 30 days at 125 mmHg (millimeter of mercury, a manometric unit of pressure) continuously, the nurses failed to transcribe the order for the correct frequency. As a result, this NPWT was never changed at the correctly ordered frequency. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 4/23/24, the Wound Physician recommended a foley catheter (a medical device that helps drain urine from the bladder) as urine will cause wound vac to lose suction. A foley catheter was not implemented until 7/11/24, 80 days after the Wound Physician initially recommended the placement of a foley catheter, when Resident #85 was admitted to the hospital for severe sepsis secondary to a sacral wound infection. During an interview on 7/31/24 at 3:58 P.M., Nurse #17 said she was the nurse who first identified Resident #85's new necrotic area. Nurse #17 said she never had any wound competencies completed at the facility since she was hired on 9/29/22. The surveyor reviewed Nurse #17's education file which failed to indicate any evidence of the required competencies for skin prevention/wound program, treatment administration, transcribing order, change in condition, or communication. During an interview on 7/31/24 at 7:39 A.M., Nurse #2 said she never had any wound competencies completed at the facility since she was hired on 3/8/24. Nurse #2 said she never had any competencies completed since she was hired, including topics such as treatment administration, transcribing orders, skin prevention/wound program, change in condition, or communication. On 7/29/24 1:51 P.M., the surveyor observed Nurse #14 provide wound care on a different resident, during which infection control concerns were noted with failing to perform hand hygiene. Nurse #14 said she had never had any wound competencies completed at the facility since she was hired on 9/6/23. Nurse #14 said she never had any competencies completed since she was hired, including topics such as treatment administration, transcribing orders, skin prevention/wound program, change in condition, or communication. During an interview on 7/31/24 at 9:16 A.M., Physician #2 said he expected that nurses providing wound care would have training completed specific for wound care. During an interview on 8/1/24 at 11:31 A.M., CNA #8 said she had never had any skin prevention competencies completed at the facility since she was hired on 6/27/22. The surveyor requested staff education files with all competencies for 5 Certified Nurse Assistants (CNA) and 12 Licensed Nurses on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 12 Licensed Nurses education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 12 Licensed Nurses had competencies completed for skin prevention/wound program - 0 out of 12 Licensed Nurses had competencies completed for transcribing orders. - 0 out of 12 Licensed Nurses had competencies completed for treatment administration - 0 out of 12 Licensed Nurses had competencies completed for colostomy care. - 0 out of 12 Licensed Nurses had competencies completed for change in condition. - 0 out of 12 Licensed Nurses had competencies completed for communication. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 5 Certified Nurse Assistant (CNA) education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 5 CNA's had competencies completed for preventative skin care. 2.) Throughout the Recertification Survey (7/23/24 through 7/26/24 and 7/29/24 through 8/1/24) the surveyors identified concerns across multiple care areas including but not limited to: - Medication administration - IV (intravenous) administration - Documentation - CPAP (continuous positive airway pressure) - Restraints - Weights - Psychotropic medication consents - Resident Rights - Advanced Directives Review of the Facility Assessment Tool, dated 5/24/24, indicated the following competencies should be completed for licensed nurses on hire and PRN: - CPAP/BIPAP (bilevel positive airway pressure) - Side rails/restraint policy and procedure - Weights - Nutritional Program - Psychotropic medication consents - IV Therapy - programming pump, peripheral, central lines - DNR (do not resuscitate) Order - Consents, DNR, Advanced Directives, Psychotropic medication Review of the Facility Assessment Tool, dated 5/24/24, indicated the following competencies should be completed for licensed nurses annually: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Medication administration - IV administration - Documentation Review of the Facility Assessment Tool, dated 5/24/24, indicated the following competencies should be completed for CNA's on hire and annually: - Preventative Skin Care - Weights - Resident Rights - Restraint and Ambulation The surveyor requested staff education files with all competencies for 5 Certified Nurse Assistants (CNA) and 12 Licensed Nurses on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 12 Licensed Nurses education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 12 Licensed Nurses had competencies completed for CPAP/BIPAP. - 0 out of 12 Licensed Nurses had competencies completed for side rails/restraint policy and procedure. - 0 out of 12 Licensed Nurses had competencies completed for weights. - 0 out of 12 Licensed Nurses had competencies completed for Nutritional Program - 0 out of 12 Licensed Nurses had competencies completed for Psychotropic medication consents - 0 out of 12 Licensed Nurses had competencies completed for IV administration. - 0 out of 12 Licensed Nurses had competencies completed for IV Therapy - programming pump, peripheral, central lines - 0 out of 12 Licensed Nurses had competencies completed for DNR Order - 0 out of 12 Licensed Nurses had competencies completed for Consents, DNR, Advanced Directives, Psychotropic medication. - 0 out of 12 Licensed Nurses had competencies completed for Medication administration. - 0 out of 12 Licensed Nurses had competencies completed for documentation. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of 5 Certified Nurse Assistant (CNA) education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 5 CNA's had competencies completed for weights. - 0 out of 5 CNA's had competencies completed for resident rights. - 0 out of 5 CNA's had competencies completed for restraint and ambulation. During an interview on 7/29/24 1:51 P.M., Nurse #14 said she never had any nursing competencies completed at the facility since she was hired. During an interview on 7/31/24 at 3:58 P.M., Nurse #17 said she never had any nursing competencies completed at the facility since she was hired. During an interview on 7/31/24 at 7:39 A.M., Nurse #2 said she never had any nursing competencies completed at the facility since she was hired. During an interview on 8/1/24 at 11:31 A.M., CNA #8 said she had never had CNA specific competencies completed since she was hired, including restraints or resident rights. During an interview on 8/1/24 at 1:01 P.M., Nurse #19 said she used to be the Staff Development Nurse a few months ago. Nurse #19 said nursing competencies were not being completed for nurses or CNA's. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse said nursing competencies haven't been completed in years. The Staff Development Nurse said she knew these should have been done, but they had not had the time or a consistent person in the position. During an interview on 7/31/24 at 11:10 A.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said nursing competencies such as medication administration, IV administration, and documentation, should have been completed based on the facility assessment for all nurses upon hire, annually and as needed to prove their competency for these skills before providing care to Residents in the facility. The DON and ADON said these competencies should be documented and readily available but were not. The DON and ADON said all nursing competencies were not being completed because they had trouble filling the staff development nurse position. The DON and ADON said they knew these should have been done, but they had not had the time or resources. The DON and ADON further said that the position had been vacant for a long time and then had multiple turnovers recently. Ref to F835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on personnel file review and interviews, the facility failed to ensure that 2 of 5 Certified Nurse Assistants (CNA's) reviewed were not employed as CNA's for more than four months after hire without having completed the competency evaluation program approved by the State of Massachusetts. Findings include: Review of the Massachusetts Nurse Aide Registry information for employers indicated the following: - You can employ a Nurse Aide who has not yet taken and passed the CNA test for no more than 4 months. 1.) Review of CNA #9's personnel file indicated she was hired on [DATE] for the position of CNA. CNA #9's personnel file also indicated she had a certificate of completion from a state approved nurse aid training program, dated [DATE]. Review of the Massachusetts Nurse Aide Registry indicate that CNA #9 was not issued Nurse Aide Certification until [DATE], which is 23 months and 6 days after completing the nurse aid training program. Review of CNA #9's Time Card Report, dated [DATE] to [DATE], indicated CNA #9 had worked as a CNA for a total of 2,266 hours since [DATE], after over a year without having passed the CNA test. During an interview on [DATE] at 9:49 A.M., the Business Office Manager said she was responsible for ensuring direct care staff had necessary licensure for their job title. The Business Office Manager said CNA #9 had been a full-time nurse aide since [DATE]. The Business Office Manager said CNA #9 had completed a nurse aide training program on [DATE] and during that time there had a waiver that allowed her to work for an extended time before taking the CNA test. The Business Office Manager said she was unaware that the waiver had expired in [DATE]. The Business Office Manager said she did not contact the Nurse Aide Registry program for an extension and there were not extenuating circumstances, it was just not scheduled in time. The Business Office Manager said the test should have been taken before the waiver expired in [DATE] but was not. During an interview on [DATE] at 12:14 P.M., the Director of Nursing (DON) said there is no other way for a CNA to have competency proven than by taking the CNA test. The DON said CNA #9 should have taken, and passed, the CNA test within 4 months of completing a state-approved nurse aide program, or else they should not be working in the capacity of a CNA. 2.) Review on CNA #8's personnel file indicated she was hired on [DATE] for the position of CNA. CNA #8's personnel file failed to indicated that she had a certificate of completion from a state approved nurse aid training program. Review of the Massachusetts Nurse Aide Registry failed to indicate that CNA #8 was ever issued a Nurse Aide Certification. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CNA #9's Timecard Report, dated [DATE] to [DATE], indicated CNA #8 had worked as a CNA for a total of 906.25 hours since she was hired, which is 5 months and 26 days after date of hire, without having passed the CNA test. During an interview on [DATE] at 9:49 A.M., the Business Office Manager said she was responsible for ensuring direct care staff had necessary licensure for their job title. The Business Office Manager said CNA #8 had been a full-time nurse aide since [DATE]. The Business Office Manager was unable to locate CNA #8's certificate of completion of the nurse aide training program but said CNA #8 had completed a nurse aide training program prior to date of hire. The Business Office Manager said CNA #8 had not passed the CNA test yet. The Business Office Manager said she did not contact the Nurse Aide Registry program for an extension and there were not extenuating circumstances, it was just not scheduled in time. The Business Office Manager said the test should have been taken within 4 months of hire but was not. During an interview on [DATE] at 12:14 P.M., the Director of Nursing (DON) said there is no other way for a CNA to have competency proven than by taking the CNA test. The DON said CNA #8 should have taken, and passed, the CNA test within 4 months of completing a state-approved nurse aide program, or else they should not be working in the capacity of a CNA.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 48990 Based on personnel file review and interview, the facility failed to ensure annual performance reviews were completed at least every 12 months for 2 of 3 Certified Nurse Aides (CNAs) personnel files reviewed. Findings include: Review of the Facility Assessment, dated 5/24/24, indicated: 3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. -The itemized list of education provided at orientation included: Annual In-service Education requirements, Dementia Training. - All departments receive an initial 8 hours of dementia training and 4 hours annually. The surveyor requested personnel files for 3 Certified Nurse Aides (CNAs) who were employed by the facility for over 12 months on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P. M., and 8/1/24 at 7:47 A.M. Review of 3 Certified Nurse Aides (CNAs) personnel files, who had been employed by the facility for over 12 months, indicated: - 2 out of 3 failed to include documentation of an annual performance review. During an interview on 8/1/24 at 7:40 A.M., the Staff Development Nurse said all Certified Nurse Aides (CNAs) are required to have an annual performance review every 12 months but was unable to locate documentation of an annual performance review for 2 of the 3 personnel files reviewed by the surveyor. During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said all Certified Nurse Aides (CNAs) are required to have an annual performance review every 12 months and documentation of completion should be readily available.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44095 Based on record review and interviews, the facility failed to provide routine medications to two Resident (#86 and #92) out of a total sample of 39 residents. Specifically, 1. For Resident #86, the facility failed to provide eliquis (anticoagulant medication) as ordered by the physician. 2. For Resident #92, the facility failed to provide two scheduled doses of klonopin (an antianxiety medication) as ordered by the physician. Findings Include: Review of the facility policy titled Unavailable Medications, dated as revised December 2019, indicated that medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. B. Nursing staff shall: 1.) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapies that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. b. Obtain a new order and cancel/discontinue the order for the non-available medication. c. Notify the pharmacy of the replacement order. 1. Resident #86 was admitted to the facility in May 2024 with diagnoses including inflammation and infection reaction due to unspecified internal joint prosthetic. On 7/23/24 at 10:25 A.M., the surveyor observed Nurse #2 prepare and administer medications to Resident #86. Nurse #2 said she did not have Resident #86's eliquis and she was going to document the eliquis as unavailable. Review of Resident #86's physician's order, dated 7/22/24, indicated: - Eliquis Oral Tablet 2.5 milligrams (mg) (apixaban), give 1 tablet by mouth two times a day related to infection and inflammatory reaction due to unspecified internal joint prosthesis. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #86's eMAR- Medication Administration Note, dated 7/23/2024 at 10:34 A.M., indicated: Eliquis Oral Tablet 2.5 mg, give 1 tablet by mouth two times a day related to infection and inflammatory reaction due to unspecified internal joint prosthesis. -Drug is not available/Pharmacy notified. Review of the cubex inventory, dated as current on 7/23/24, indicated the kit contained 10 tablets of apixaban (eliquis) 2.5 mg tablets that were available for nursing to administer. During an interview on 7/25/24 at 4:00 P.M., Nurse #2 said she did not have eliquis to administer to Resident #86. Nurse #2 said she did not check the cubex, and said she should have. During an interview on 07/29/24 at 4:42 P.M., the Director of Nursing (DON) said Nurse #2 should have obtained the eliquis from the cubex but did not. 49880 2. Resident # 92 was admitted to the facility in July 2023 with diagnoses that include obstructive sleep apnea, multiple sclerosis, PTSD, anxiety, low back pain. Review of Resident #92's most recent Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident utilizes antianxiety medications. Review of Resident #92's physician orders indicated the following: -Klonopin (an antianxiety medication) 1 mg three times a day for anxiety, dated 4/15/24. -Klonopin 0.5 mg as needed by mouth for anxiety, dated 4/5/24. During an interview on 7/23/24 at 9:14 A.M., Resident #92 said that he/she did not receive their scheduled doses of klonopin on 7/14/24 because the facility did not have them in stock from the pharmacy. Review of Resident #92's July 2024 Medication Administration Record indicated that klonopin was not administered on 7/14/24 at 8:00 A.M. and 2:00 P.M. Review of Resident #92's progress notes from 7/14/24 failed to indicate that a physician was made aware that the medication was not available, and the Resident was not receiving it. During an interview on 7/25/24 at 1:44 P.M., Nurse #2 said that if a nurse is unable to administer the medication that is ordered to a resident, then the physician should be called to see if another medication can be given in its place. She further said that klonopin requires a prescription from the physician or nurse practitioner, and they should have been notified that a prescription was needed. Nurse #2 did not know whether klonopin was a medication that was available in the emergency pharmacy kit. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/24 at 11:04 A.M., the Director of Nurses (DON) said that when a resident misses a dose of a medication because it is unavailable, the physician should be called to see if there is an alternate medication that can be given.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44095 Based on record review and interviews the facility failed to ensure recommendations from the Monthly Medication Review conducted by the consultant pharmacist were addressed and acknowledged by the physician in a timely manner for five Residents (#13, #41, #50, #92, #35) out of a total sample of 39 residents. 1.) For Resident #13, the facility failed to ensure the attending physician and nursing reviewed and acted on the monthly pharmacy recommendations for ativan (an antianxiety medication) re-evaluation. 2.) For Resident #41, the facility failed to ensure the attending physician and nursing reviewed and acted on the monthly pharmacy recommendations to indicate duration of an as needed clonazepam (an antianxiety medication). 3.) For Resident #50, the facility failed to ensure the attending physician and nursing reviewed and acted on the monthly pharmacy recommendations for ativan re-evaluation. 4.) For Resident #92, the facility failed to ensure the attending physician and nursing reviewed and acted on the monthly pharmacy recommendations to clarify the administration times of omeprazole (a medication used to treat gastroesophageal reflux disease), re-evaluate the need for ambien (a hypnotic medication), clarify the dosage of voltaren gel (a topical pain relief medication), and to re-evaluate the need for klonopin. 5.) For Resident #35, the facility failed to ensure the attending physician and nursing reviewed and acted on the monthly pharmacy recommendations for lidocaine (pain medication) patch strength. Findings Include: Review of facility policy titled Pharmacy Consultant Med Review, dated as revised 1/2023, indicated the following: -Policy: the facility shall employee/contact and maintain the services of a licensed pharmacist (pharmacy consultant), who shall review the medication regimen review (MRR) of each resident at least monthly and more frequently, as needed. -The Primary purpose of this review is to assist the facility maintain each resident's highest practicable level of functioning and quality of life, by helping then utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. -Procedure: -2. The Pharmacy Consultant should report irregularities to the attending physician, medical director, and Director of Nurses (DON) with the resident's medication regime. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3. The Pharmacy Consultant will document his/her findings and recommendations on the monthly drug/regime review report. -4. The DON will give the Unit Manager or Designee, a copy of the unit's monthly pharmacy consultant report. -5. The Unit Manager/ Designee will make sure: -a. All recommendations are acted upon. -b. All of the recommendations are reported to the resident physicians. c. There is documentation in the resident chart that notification and follow up occurred. d. Notify the resident's physician to of the Pharmacy Consultant's recommendations and document in the resident's chart that this was done. 8. The Pharmacy consultant should produce and submit a report, at least quarterly the includes, but is not limited to: [sic] -b. Staff performance in complying with regulatory requirements related to medication utilization and monitoring. 1.) Resident #13 was admitted to the facility in April 2024 with diagnoses including asthma, obstructive sleep apnea, schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/18/24, indicated that Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of Resident #13's physician's order, dated 4/11/24, indicated: - Lorazepam Oral Tablet 0.5 milligram (mg) (Ativan) *Controlled Drug*, give 0.5 mg by mouth every 8 hours as needed (PRN) for anxiety. Review of Resident #62's pharmacy consultant recommendations, dated 6/20/24 and 7/2/24, indicated the following: - Recommendation to the physician (MD): re-evaluate PRN Ativan. Review of Resident #13's Medication Administration Record (MAR), dated July 2024, indicated he/she received as needed Ativan on the following dates: - 7/4/24, 7/5/24, 7/12/24, 7/14/24 During an interview on 7/31/24 at 8:16 A.M., Nurse #7 said pharmacy recommendations come in monthly, the Assistant Director of Nursing and the Director of Nursing add them to the provider book for review. Nurse #7 said she has not seen pharmacy recommendations in a long time. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/24 at 4:29 P.M., the Director of Nursing said that pharmacy recommendations should be printed and given to the providers to be addressed monthly. 48990 2.) Resident #41 was admitted to the facility in August 2023 with diagnoses including chronic pain. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/11/24, indicated that Resident #41 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #41's physician's order, initiated 11/3/23, indicated: - Klonopin Oral Tablet 1 mg (Clonazepam), give 1 tablet by mouth every 24 hours as needed. Review of Resident #41's July Medication Administration Record (MAR) indicated the Resident received a PRN dose of clonazepam on 7/5/24, 7/6/24, and 7/7/24. Review of Resident #41's pharmacy consultant recommendations, dated 3/7/24, 4/4/24, 5/7/24, and 6/3/24, indicated: - Rec (recommendation) to MD (medical doctor): indicate duration of PRN (as needed) Clonazepam. During an interview on 7/24/24 at 10:18 A.M., Nurse #14 said the nurses are not responsible for pharmacy recommendations and that the Director of Nursing was responsible for communication regarding pharmacy recommendations. During an interview on 7/25/24 at 10:15 A.M., Nurse Practitioner (NP) #1 said she is made aware of pharmacy recommendations by chance if she happens to find one while reviewing the record. NP #1 said a member of the facility never gives her a form containing pharmacy recommendations. During an interview on 7/24/24 at 10:33 A.M., the Director of Nursing (DON) said when the pharmacy sends recommendations, she prints them off and gives them to NP #1. The DON said the pharmacy recommendations should be reviewed by the provider within seven days. The DON said the pharmacy recommendation to indicate the duration of as needed clonazepam for Resident #41 was never printed or given to the provider to address but should have been. 3.) Resident #50 was admitted to the facility in November 2023 with diagnoses including diabetes and chronic pain. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/28/24, indicated that Resident #50 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #50's physician's order, initiated 3/15/24, indicated: -Ativan Oral Tablet 1 mg (Lorazepam), give 1 tablet by mouth every 12 hours as needed. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's July Medication Administration Record (MAR) indicated the Resident received a PRN dose of lorazepam on 7/4/24. Review of Resident #50's pharmacy consultant recommendations, dated 5/6/24 and 6/3/24, indicated: - Rec (recommendation) to MD (medical doctor): PRN (as needed) Ativan re-eval. During an interview on 7/24/24 at 10:18 A.M., Nurse #14 said the nurses are not responsible for pharmacy recommendations and that the Director of Nursing (DON) was responsible for communication regarding pharmacy recommendations. During an interview on 7/25/24 at 10:15 A.M., Nurse Practitioner (NP) #1 said she is made aware of pharmacy recommendations by chance if she happens to find one while reviewing the record. NP #1 said a member of the facility never gives her a form containing pharmacy recommendations. During an interview on 7/24/24 at 10:33 A.M., the Director of Nursing (DON) said when the pharmacy sends recommendations, she prints them off and gives them to NP #1. The DON said the pharmacy recommendations should be reviewed by the provider within seven days. The DON said the pharmacy recommendation to re-evaluate as needed ativan for Resident #50 was never printed or given to the provider to address but should have been. 49880 4.) Resident # 92 was admitted to the facility in July 2023 with diagnoses that include obstructive sleep apnea, multiple sclerosis, PTSD, anxiety, low back pain. Review of Resident #92's most recent Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident utilizes antianxiety, antidepressant, hypnotic, and opioid medications. Review of Resident #92's pharmacist consultant notes indicated the following: - Recommendations to clarify the administration times of omeprazole (a medication used to treat gastroesophageal reflux disease) currently scheduled at 8:00 A.M. and 2:00 P.M., re-evaluate for as needed Ambien (a hypnotic medication), and clarify the amount of Voltaren gel (a topical pain relief medication) to be applied as needed to the lower back were made on the following dates: 8/1/23, 9/5/23, 10/2/23, 11/4/23, 12/4/23, 1/2/24, 2/5/24, 3/7/24, 4/3/24, 5/6/24, 6/3/24 and 7/1/24. - Recommendations to re-evaluate as needed Klonopin (an antianxiety medication) use were made on the following dates: 2/5/24, 6/3/24 and 7/1/24. Review of Resident #92's active physician's orders indicated the following: -Klonopin 0.5 mg as needed by mouth for anxiety, dated 4/5/24. -Ambien 5 mg once time daily as needed for sleep, dated 7/27/23. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Omeprazole 40 mg two times daily to be given at 8:00 A.M. and 2:00 P.M. Further Review of Resident #92's progress notes failed to indicate that a physician was notified of the Pharmacy Consultant's recommendations. Review of Resident #92's medical record failed to indicate a printed copy of the Consultant Pharmacist's Monthly Medication Regime Review that was reviewed and signed by a physician or nurse practitioner. During an interview on 7/25/24 at 1:44 P.M., Nurse #2 said she is not aware of the process in the facility for addressing monthly pharmacy recommendations. Nurse #2 said that she did not realize that it was done monthly. During an interview on 7/25/24 at 10:15 A.M., Nurse Practitioner (NP) #1 said she is made aware of pharmacy recommendations by chance if she happens to find one while reviewing the record. NP #1 said a member of the facility never gives her a form containing pharmacy recommendations. During an interview on 7/26/24 at 11:04 A.M., the Director of Nurses (DON) said that monthly consultant pharmacist recommendations are sent to both her and the Assistant Director of Nurses (ADON) in the center. She said that they are printed and given to the Nurse Practitioner to Review. Review with the consultant pharmacist of the most recent quarterly report for July 2024, dated 6/30/24, indicated that from 4/1/24 to 6/30/24 the facility had a response rate of 24.5% to the consultant pharmacist's month recommendations. During an interview on 7/31/24 at 1:06 P.M., the Consultant Pharmacist said that she completed the MRR and then she emails them to the DON and ADON in the facility. She said that when she tries to follow up on recommendations that have not been responded to, she does not get a response from the facility. 50338 5.) Resident #35 was admitted to the facility in February 2024 with diagnoses including stroke affecting left side, diabetes, and post-traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/22/24, indicated that Resident #35 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Review of Resident #35's physician's order, initiated 2/15/24, indicated: - Lidocaine External Patch. Apply to skin topically once a day for pain. Review of #35's pharmacy consultant's medication regime review (MRR), dated 2/16/24, 3/8/24, 4/5/24, 5/7/24, 6/4/24, and 7/2/24, indicated the following: -recommendation to physician (MD): include strength of Lidocaine patch. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/24 at 8:15 A.M., Nurse #8 said pharmacy recommendations are verbally communicated nurse and to she thinks pharmacist communicates with the physician but does not know how. She said there is not a binder or book to communicate the recommendations. During an interview on 7/31/24 at 11:46 A.M., Director of Nursing (DON) said MRR pharmacy recommendations have not been being followed, but they should be.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 44095 Based on record review and interviews, the facility failed to ensure for one Resident (#47), out of a total sample of 39 residents, that the Resident's drug regimen was free from unnecessary drugs. Specifically, the facility failed to complete a gradual dose reduction (GDR) of his/her physician's ordered Lexapro (antidepressant medication). Findings include: Review of the facility policy, Psychotropic Medication, dated as revised 2/2022, indicated that Physicians and mid-level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. 1. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. 7. Efforts to reduce dosage or discontinuation of psychopharmacological medications will be ongoing, as appropriate, for the clinical situation. Review of the facility policy titled Psychiatric Services, dated as revised 1/2023, indicated a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. 6. Medication recommendations need to be reviewed and approved by residents attending physician Resident #47 was admitted to the facility in August 2022 with diagnoses including diabetes, major depression, and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/18/24, indicated that Resident #47 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #47 received an antidepressant medication. Review of Resident #47's physician's order, dated 8/1/22, indicated: - Lexapro Tablet 10 milligrams (mg), give 1 tablet by mouth one time a day related to anxiety and major depression. Review of Resident #47's plan of care related to psychotropic medications, dated as revised 1/4/24, indicated: - Discuss with physician, family with ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Review of Resident #47's psychiatric evaluation and consultation, dated 6/17/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Current Assessment: Patient seen for follow up on mental health. He/she does not appear to be in any distress. He/she reports stable mood with continued relief from his/her depressive symptoms. He/she endorses stable energy levels and concentration. His/her sleep pattern has normalized, with no complaints of insomnia or hypersomnia. He/she denies suicidal ideation, hopelessness, or feelings of worthlessness. His/her appetite remains stable, and he/she has not experienced significant weight changes. He/she is cooperative and with a bright affect and congruent mood and psychomotor disturbances or cognitive impairments noted during the session. We did discuss reducing his/her Lexapro. Tells me he/she does not need and will try to gradual dose reduction (GDR). - Plan: I recommend decreasing Lexapro to 5 mg daily. Monitor for GDR failure. Continue to assess for mood, safety and will follow up as needed. Review of Resident #47's physician's progress note, dated 6/17/24, indicated the following: - Resident seen today in his/her room. He/she denies any pain, shortness of breath, chest pain. He/she was seen by Psychiatric Nurse Practitioner (NP) today. He/she is wondering if his/her Lexapro can be decreased to 5 mg daily. He/she states that he/she has noticed some health improvements and does not feel as sad or anxious as before. He/she denies SI/HI (suicidal ideation/homicidal ideation). His/her appetite is good. Review of Resident #47's physician's progress note, dated 6/18/24, 6/24/24, 7/8/24, indicated the following: - F32.9 - Major depressive disorder, single episode, unspecified. - 6/17/24: Will decrease Lexapro to 5 mg daily. Will continue to monitor patient's mood and behavior while in long term care (LTC). Review of Resident #47's medical record on 7/25/24 failed to indicate the Lexapro was decreased. During an interview on 7/25/24 at 8:33 A.M., Resident #47 said he/she met with the psychiatric nurse practitioner and asked for his/her Lexapro to be decreased. Review of Resident #47's psychiatric evaluation and consultation, dated 7/26/24, indicated: - I did recommend decreasing Lexapro to 5 mg in my previous visit appears order was not put in the electronic medical record. During an interview on 7/24/24 at 6:22 A.M., Nurse #7 said that psychiatric recommendations are reviewed and implemented by the Assistant Director of Nursing and Director of Nursing. During an interview on 7/25/24 at 10:12 A.M., Nurse Practitioner #1 said Resident #47's Lexapro should have decreased according to the psychiatric nurse practitioner's recommendations. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 11:04 A.M., Physician #1 said that he should have implemented the gradual dose reduction, but he did not. During an interview on 7/29/24 at 4:01 P.M., the Director of Nursing said that the physician should have implemented the psychiatric nurse practitioner's recommendations but did not.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44095 Based on record review and interviews the facility failed to ensure that PRN [as needed] ordered psychotropic drugs were limited to 14 days for four Residents (#13, #50, #41, #92) out of a total sample of 42 residents. Specifically, 1. For Resident #13, the facility failed to implement a 14 day stop date for PRN ativan (an antianxiety medication). 2. For Resident #41, the facility failed to implement a stop date or re-evaluation for use of PRN clonazepam (an antianxiety medication). 3. For Resident #50, the facility failed to implement a stop date or re-evaluation for use of PRN ativan (an antianxiety medication). 4. For Resident #92, the facility failed to implement a stop date or re-evaluation for use of PRN Klonopin (an antianxiety medication) and PRN Ambien (a hypnotic medication). Findings Include: Review of facility policy titled Psychotropic Medications, dated as revised 10/2022, indicated the following: -Psychotropic drugs- any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to drugs in the following categories: -Anti-psychotic -Anti-anxiety -Anti-depressant -Hypnotic -13. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 14. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. 1.) Resident #13 was admitted to the facility in April 2024 with diagnoses including asthma, obstructive sleep apnea, schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 7/18/24, indicated that Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of Resident #13's physician's order, dated 4/11/24, indicated: - Lorazepam Oral Tablet 0.5 milligram (mg) (Ativan) *Controlled Drug*, give 0.5 mg by mouth every 8 hours as needed (PRN) for anxiety. Review of Resident #62's pharmacy consultant recommendations dated 6/20/24 and 7/2/24, indicated the following: Recommendation to the physician (MD): re-evaluate PRN Ativan Review of Resident #13's Medication Administration Record (MAR), dated July 2024, indicated he/she received as needed Ativan on the following dates: -7/4/24, 7/5/24, 7/12/24, and 7/14/24. During an interview on 7/31/24 at 8:18 A.M., Nurse #7 said that Resident #13's Ativan order needs a 14 day stop date. During an interview on 8/1/24 at 4:12 P.M., Nurse #13 said Ativan needs a 14 day needs a stop date. During an interview on 7/29/24 at 4:31 P.M., the Director of Nursing said Resident #14's Ativan should have a 14 day stop date. 48990 2.) Resident #41 was admitted to the facility in August 2023 with diagnoses including chronic pain, anxiety, and panic disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/11/24, indicated that Resident #41 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #41's physician's order, initiated 11/3/23, indicated: - Klonopin Oral Tablet 1 mg (milligrams) (Clonazepam), Give 1 tablet by mouth every 24 hours as needed. Review of Resident #41's July Medication Administration Record (MAR) indicated the Resident received a PRN dose of clonazepam on 7/5/24, 7/6/24, and 7/7/24. Review of the pharmacist consultant notes, dated 3/7/24, 4/4/24, 5/7/24, and 6/3/24, indicated: - Rec to MD (medical doctor): indicate duration of PRN (as needed) Clonazepam. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #41's medical record failed to indicate a stop date or re-evaluation for the use of as needed (PRN) clonazepam. During an interview on 7/24/24 at 10:18 A.M., Nurse #14 said she was not aware that a PRN psychotropic medication required a stop date and re-evaluation. During an interview on 7/24/24 at 10:33 A.M., the Director of Nursing (DON) said PRN psychotropic medications need to have a stop date and that the duration of Resident #41's PRN clonazepam should have been clarified to include an end date for re-evaluation but did not. 3.) Resident #50 was admitted to the facility in November 2023 with diagnoses including chronic pain, anxiety, and post-traumatic stress disorder (PTSD). Review of the most recent Minimum Data Set (MDS) assessment, dated 5/28/24, indicated that Resident #50 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #50's physician's order, initiated 3/15/24, indicated: -Ativan Oral Tablet 1 mg (Lorazepam) Give 1 tablet by mouth every 12 hours as needed for Anxiety. Review of Resident #50's July Medication Administration Record (MAR) indicated the Resident received a PRN dose of ativan on 7/4/24. Review of the pharmacist consultant notes, dated 5/6/24 and 6/3/24, indicated: - Rec to MD (medical doctor): PRN (as needed) Ativan re-eval. Review of Resident #50's medical record failed to indicate a stop date or re-evaluation for the use of as needed (PRN) ativan. During an interview on 7/24/24 at 10:18 A.M., Nurse #14 said she was not aware that a PRN psychotropic medication required a stop date and re-evaluation. During an interview on 7/24/24 at 10:33 A.M., the Director of Nursing (DON) said PRN psychotropic medications need to have a stop date and that the duration of Resident #50's PRN ativan should have been clarified to include an end date for re-evaluation but did not. 49880 4. Resident # 92 was admitted to the facility in July 2023 with diagnoses that include obstructive sleep apnea, multiple sclerosis, PTSD, anxiety, low back pain Review of Resident #92's most recent Minimum Data Set (MDS) Assessment, dated 7/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident utilizes antianxiety, antidepressant, hypnotic, and opioid medications. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #92's physician orders indicated the following: -Klonopin 0.5 mg as needed by mouth for anxiety, dated 4/5/24. -Ambien (a hypnotic medication) 5 mg once time daily as needed for sleep, dated 7/27/23. Review of Resident #92's progress notes indicated the following pharmacy consultant recommendations: -Recommendations to re-evaluate as needed Ambien (a hypnotic medication) use were made on the following dates; 8/1/23, 9/5/23, 10/2/23, 11/4/23, 12/4/23, 1/2/24, 2/5/24, 3/7/24, 4/3/24, 5/6/24, 6/3/24 and 7/1/24. -Recommendations to re-evaluate as needed Klonopin (an antianxiety medication) use were made on the following dates: 2/5/24, 6/3/24 and 7/1/24. Review of Resident #92's medical record failed to indicate a stop date for the use of as needed (PRN) Klonopin and PRN Ambien. Review of Resident #92's July Medication Administration Record indicated that Resident #92 received PRN Klonopin on 7/20/24 and PRN Ambien on 7/8/24 and 7/11/24. During an interview on 7/25/24 at 1:44 P.M., Nurse #2 said she was not aware that a PRN psychotropic medication requires a 14-day stop date and re-evaluation. During an interview on 7/26/24 at 11:04 A.M., the Director of Nurses (DON) said that all PRN psychotropic medications should have a stop date of 14 days and should be re-evaluated by the practitioner.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44095 Based on observations, record review, policy review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when 4 out of 5 nurses observed made 9 errors out of 30 opportunities, resulting in a medication error rate of 30%. Those errors impacted four Residents (#75, #86, #20 and #80), out of five residents observed. - For Resident #75, Nurse #1 failed to administer his/her medications within the one-hour time frame. - For Resident #86, Nurse #2 failed to administer his/her medications within the one-hour time frame and failed to administer the correct form of iron. - For Resident #20, Nurse #3 failed to administer his/her medications within the one-hour time frame. - For Resident #80, Nurse #4 failed to administer his/her medications within the one-hour time frame and failed to follow manufactures guidelines. Findings include: Review of the facility policy titled Medication Administration, dated as revised 10/2022, indicated the following: - Medications must be administered in accordance with the orders, including any required time frame - If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. - The medication nurse shall assure that the correct medication is administered by checking the physician's order and the medication label. - Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). - If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document as such in designated format (hard copy or electronic) space provided for that drug and dose. 1. On 7/23/24 at 10:12 A.M., the surveyor observed Nurse #1 prepare and administer morning medications to Resident #75 including the following: - baclofen 10 milligrams (mg), 1 tablet (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- gabapentin 100 mg, 1 capsule Review of Resident #75's physician orders indicated the following: - Baclofen Oral Tablet 10 mg (Baclofen), give 10 mg by mouth three times a day related to wedge compression fracture of the second lumbar vertebra. Scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M., start 2/6/24. Administered 2 hours and 12 minutes after the scheduled time. -Gabapentin Oral Capsule 100 mg (Gabapentin), give 100 mg by mouth three times a day for chronic pain. Scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M., start 10/17/23. Administered 2 hours and 12 minutes after the scheduled time. During an interview on 7/23/24 at 10:15 A.M., Nurse #1 said she was late administering medications and medications should be administered within a one-hour window. During an interview on 07/29/24 04:40 P.M., the Director of Nursing (DON) said medications should be administered within one hour of the scheduled times. 2. On 7/23/24 at 10:25 A.M., the surveyor observed Nurse #2 prepare and administer morning medications to Resident #86 including the following: - Suboxone Sublingual Film 8-2 mg (Buprenorphine HCl-Naloxone HCl Dihydrate), one sublingual paper - Calcium Acetate (Phos Binder) Oral Capsule 667 mg (Calcium Acetate), one capsule - ferrous sulfate 325 mg, 1 tablet Review of Resident #86's physician orders indicated the following: -Suboxone Sublingual Film 8-2 mg (Buprenorphine HCl-Naloxone HCl Dihydrate) *controlled drug*, give 1 film sublingually two times a day for pain. Scheduled twice daily at 8:00 A.M., and 8:00 P.M., start 5/31/24. Administered 2 hours and 25 minutes late. -Calcium Acetate (Phos Binder) Oral Capsule 667 mg (Calcium Acetate (Phosphate Binder), give 1 capsule by mouth three times a day for gastrointestinal. Scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M., start 6/15/24. Administered 2 hours and 25 minutes late. - Niferex Oral Tablet (Iron Combinations), give 150 mg by mouth one time a day for hematopoietic agents, scheduled daily at 8:00 A.M., start 5/31/24. Administered incorrect medication. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/24 at 4:00 P.M., Nurse #2 said she was late administering medications to Resident #86. Nurse #2 was unaware she gave the incorrect form of iron. During an interview on 7/29/24 at 4:42 P.M., the Director of Nursing (DON) said, medications should be administered within one hour of the scheduled times and Nurse #2 should have administered the correct iron. 3. On 7/24/24 at 10:22 A.M., the surveyor observed Nurse #3 prepare and administer morning medications to Resident #20 including the following: - omeprazole 40 mg, 1 capsule - Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 micrograms (Fluticasone-Salmeterol), 1 puff Review of Resident #20's physician orders, dated 3/29/24, indicated the following: -Omeprazole Oral Capsule Delayed Release 40 mg (Omeprazole), Give 40 mg by mouth one time a day related to dementia and anxiety, dated as 3/29/24 and scheduled daily at 7:30 A.M., Administered 2 hours and 52 minutes late. -Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 micrograms (Fluticasone-Salmeterol), 1 puff inhale orally two times a day related to dementia with anxiety, dated as 3/29/2024 and scheduled twice daily at 8:00 A.M., and 8:00 P.M., Administered 2 hours and 22 minutes late. During an interview on 7/24/24 at 10:29 A.M., Nurse #3 said he was late administering medications. He said medications should be administered within a one-hour window. During an interview on 7/29/24 at 4:43 P.M., the Director of Nursing (DON) said medications should be administered within one hour of the scheduled times. 4. On 7/25/24 at 9:08 A.M., the the surveyor observed Nurse #4 prepare and administer morning medications to Resident #80 including the following: - cogentin 0.5 mg, 1 tablet - zipradone 80 mg, 1 capsule, opened and added to apple sauce Review of Resident #80's physician order indicated the following: - Bzotropine Mesylate Tablet 0.5 mg, give 1 tablet by mouth two times a day for tremors. Scheduled twice daily at 8:00 A.M., and 8:00 P.M., start 6/26/22. Administered 1 hour and 8 minutes late. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ziprasidone HCl Capsule 80 mg, give 1 capsule by mouth two times a day related to schizophrenia. Scheduled twice daily at 8:00 A.M., and 8:00 P.M., 9/20/22. Review of the manufacture's guidelines indicate for the medication to take whole, do not open. During an interview on 7/25/24 at 11:59 A.M., Nurse #4 said that medications should be administered within one hour of the scheduled time. Nurse #4 reviewed the manufactures guidelines with the surveyor and said she should not have opened the capsule of ziprasidone. During an interview on 7/29/24 at 4:43 P.M., the Director of Nursing (DON) said medications should be administered within one hour of the scheduled times.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 44095 Based on record review and interviews for one Resident (#24) out of 39 sampled residents, the facility failed to ensure that the Resident was free from a significant medication error. Specifically, the facility failed to ensure a blood pressure medication (midodrine) was scheduled to be administered in accordance with the physician's order which indicated that the medication be administered before meals. Findings include: Review of the facility policy, Medication Administration, dated as revised 10/2022, indicated the following: 3. Medications must be administered in accordance with the orders, including any required time frame. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #24's hospital after visit summary, dated 5/3/24, indicated: - midodrine 5 milligrams (mg), take one tablet by mouth three times a day before meals, hold for a systolic blood pressure greater than 140. Review of Resident #24's physician's order, dated 5/3/24, indicated: -Midodrine HCl oral tablet 5 mg (Midodrine HCl), give one tablet by mouth three times a day related to hypertension, take before meals. Hold for systolic blood pressure greater than 140. Further review of the physician's order indicated the medication was scheduled to be administered at 8:00 A.M., 2:00 P.M., and 8:00 P.M. Review of Resident #24's Medication Administration Record (MAR), dated May 2024, June 2024, and July 2024, indicated the midodrine was administered three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M. Review of Resident #24's consultant pharmacy report, dated as 5/7/24, 6/4/24, and 7/2/24, indicated: - Recommendation to Nursing: midodrine administration times. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/31/24 at 4:36 P.M., Nurse #17 said she obtained the physician's order for the midodrine from the hospital discharge summary. Nurse #17 said she did not schedule the midodrine before meals but should have. During an interview on 7/29/24 at 11:45 A.M., the surveyor and Nurse #15 reviewed Resident #24's midodrine order. Nurse #15 said the medication was not scheduled according to the physician's orders for before meals. Further review of Resident #24's MAR, dated July 4 to July 20, 2024, indicated Nurse #15 administered Resident #24 the midodrine three times at 2:00 P.M., and one time at 8:00 P.M. During an interview on 8/1/24 at 4:16 P.M., Nurse #13 said he routinely cares for Resident #24 during the evening shift. Nurse #13 said he was not aware of the additional instructions to administer the midodrine with meals. Further review of Resident #24's MAR, dated July 1 to July 20, 2024, indicated Nurse #15 administered Resident #24's midodrine 13 times at 8:00 P.M. During an interview on 7/29/24 at 4:09 P.M., the Director of Nursing said the midodrine should have been scheduled before meals.scheduled before meals.		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44095 Based on observation, interviews and record review the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to: 1.) Ensure medications with shortened expiration dates were dated once opened. 2.) Ensure medication and treatment carts were locked when unattended. 3.) Ensure medications were stored in the original, labeled containers. 4.) Ensure medications were stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel. 5.) For Resident #38, the facility failed to ensure that self-administered medications were stored securely when not in use. Findings include: Review of the facility policy, Medication Storage, dated as revised ,d+[DATE], indicated to provide guidelines for proper storage of medications within the facility. This center will have Medications stored in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance with department of health guidelines. 1. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. 3. Medications will be stored in an orderly, organized manner in a clean area. 5. Medications will be stored in the original, labeled containers received from the pharmacy. 6. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. 7. Multidose vials: b. Multi-dose vials which have been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) The facility failed to ensure that medications with a shortened expirations date were dated once opened. a. On [DATE] at 6:50 A.M., the surveyor and Nurse #2 observed the following on the [NAME] Unit medication cart 1: - one bottle of proheal (liquid protein supplement), opened and undated, manufactures guidelines indicated good for 60 days once opened. - three fluticasone furoate umeclidinium vilanterol inhalation powder, inhaler opened and undated, manufactures guidelines indicated good for six weeks once opened. - one umeclidinium and vilanterol inhalation powder, open and undated, - one bottle of dorzolamide HCL and timolol maleate, ophthalmic solution, opened and undated, - one bottle of brimonidine tartrate ophthalmic solution, opened and undated, - one bottle of insulin glargine, opened and undated, and - one bottle of atropine ophthalmic drops, open and undated. b. On [DATE] at 6:51 A.M., the surveyor observed a [NAME] Unit medication cart 2 which contained the following: - an open, undated bottle of proheal (a liquid protein supplement). - an open, undated vial of humalog insulin. c. On [DATE] at 7:05 A.M., the surveyor and Nurse #9 observed the following on the [NAME] Unit medication cart 2: - one plastic cup with one pill in it labelled vitamin C 500, - one suboxone 4mg/ 1mg, in the top of the medication drawer and not double locked, and - one bottle of proheal liquid protein, opened and undated. d. On [DATE] at 7:19 A.M., the surveyor and Nurse #7 observed the following on the [NAME] Unit medication cart 1: - one travoprost ophthalmic solution, opened and undated, - one bottle of proheal, opened and undated, - three fluticasone propionate and salmeterol inhalation powder, opened and undated, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10 loose Ipratropium bromide/albuterol sulfate inhalers, not in the foil pouch, manufactures guidelines indicate to store in foil pouch. During an interview on [DATE] at 4:35 P.M., the Director of Nursing said opened medications should be stored and dated according to manufacturer's guidelines. 2. Medication Carts and Treatment Carts were unlocked when unattended. a. On [DATE] at 6:45 A.M., the surveyor observed the [NAME] Unit medication cart 1, unlocked and unattended. During an interview on [DATE] at 6:47 A.M., Nurse #2 said that the medication cart should be locked when unattended. b. On [DATE] at 6:51 A.M., the surveyor observed a [NAME] Unit medication cart 2, unlocked and unattended. The surveyor opened the drawers which contained multiple medications. During an interview on [DATE] at 6:55 A.M., Nurse #12 said the medication cart should have been locked since it was unattended. c. On [DATE] at 7:17 A.M., the surveyor observed the [NAME] Unit treatment cart, unlocked and unattended. During an interview on [DATE] at 7:19 A.M., Nurse #7 said the treatment cart should be locked when unattended. d.) On [DATE] at 8:37 A.M., the surveyor observed a [NAME] Unit medication cart 1, unlocked and unattended. The surveyor opened the drawers which contained multiple medications. During an interview on [DATE] at 8:39 A.M., Nurse #2 said the medication cart should have been locked since it was unattended. e.) On [DATE] at 9:46 A.M., the surveyor observed the [NAME] Unit treatment cart, unlocked and unattended. The surveyor opened the drawers which contained multiple tubes of medicated treatments and prescription creams. During an interview on [DATE] at 9:55 A.M., Nurse #7 said the treatment cart should have been locked since it was unattended. f.) On [DATE] at 3:22 P.M., the surveyor observed the [NAME] Unit treatment cart was unlocked and unattended. There were 2 Residents ambulating near the treatment cart. g.) On [DATE] at 6:38 A.M., the surveyor observed the [NAME] Medication cart 1, unlocked and unattended, and [NAME] treatment cart unlocked and unattended. On the [DATE] at 6:42 A.M., the Staff Development Coordinator locked the medication cart and treatment cart and she said they should be locked when unattended. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 6:45 A.M., Nurse #6 said the medication and treatment carts should have been locked but were not. During an interview on [DATE] at 4:36 P.M., the Director of Nursing said medication carts and treatment carts should be locked when unattended. 48990 3.) On [DATE] at 6:50 A.M., the surveyor observed [NAME] Unit medication cart 2 which contained six uncovered medication cups containing pre-poured pills. One of the medication cups, containing three identical orange pills with imprints of P and 2, had a label on it indicating dilaudid (a narcotic pain medication). On [DATE] at 8:38 A.M., the surveyor observed a [NAME] Unit medication cart which contained one uncovered medication cup containing a pre-poured white pill. During an interview on [DATE] at 6:55 A.M., Nurse #12 said the medication cup, that was filled with the three orange pills, were three dilaudid pills. Nurse #12 said dilaudid is a narcotic pain medication which should always be locked in the separate locked container of the medication cart because it's a controlled substance. Nurse #12 said medications should never be pre-poured and should only be put into medication cups immediately before administration. Nurse #12 said if medications were refused, they should be discarded immediately and should never be stored in medication cups in the medication cart. During an interview on [DATE] at 10:02 A.M., the Director of Nursing (DON) said medications should never be pre-poured into medication cups. The DON said pills are expected to be prepared and dispensed into medication cups directly before administering them each resident and should never be stored in medication cups in the medication cart, and specifically controlled substances, such as dilaudid, should be stored in the separate locked container in the medication cart. 4.) During a tour of the [NAME] Unit on [DATE] at 8:11 A.M., the surveyor made the following observations: - a medication cup tipped on its side with a blue pill inside the cup and a white pill laying directly on the bedside table. The Resident said the nurse left it on his/her bedside an hour ago because he/she was sleeping, and they had to tend to something else. During an interview on [DATE] at 10:02 A.M., the Director of Nursing (DON) said medications should never be left at the bedside and the nurse should stay with the resident to visualize administration. 45763 5.) Review of the facility policy, titled self-administration of medications, revised [DATE], indicated, but was not limited to, the following: - Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Storage should be in a locked box in the resident's drawer. b. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. - Staff shall identify and give to the charge nurse any medications found at bedside that are not authorized for self-administration, for return to the family or responsible party. Resident #38 was admitted to the facility in February 2023 with a diagnosis of chronic respiratory failure with hypoxia. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #85 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Review of Resident #38's physician orders indicated the following active orders: - PT (patient) may self-administer inhalers, may keep at the bedside, initiated on [DATE]. - Advair diskus (a long-acting bronchodilator used to treat asthma and chronic obstructive pulmonary disease (COPD) inhalation aerosol powder breath, initiated [DATE]. - Tiotropium Bromide Monohydrate capsule 18 Mg (a long-acting bronchodilator used to treat asthma and COPD), initiated [DATE]. Review of Resident #38's self-administration evaluations, dated [DATE] and [DATE], indicated the Resident was capable of self-administering medication. On [DATE] at 8:45 A.M., the surveyor observed Resident #38 in his/her room, there was an Advair and tiotropium bromide monohydrate inhaler on the Resident's bedside table. Resident #38 resides on a unit with residents who wander, and staff are required to enter a code to gain entrance and to exit from his/her unit. On [DATE] at 8:01 A.M., the surveyor observed Resident #38 sleeping in his/her room, there was an Advair and tiotropium bromide monohydrate inhaler on the Resident's bedside table. On [DATE] at 12:35 P.M., the surveyor observed Resident #38 sleeping in his/her room, there was an Advair and tiotropium bromide monohydrate inhaler on the Resident's bedside table. On [DATE] at 7:57 A.M., the surveyor observed Resident #38 sleeping in his/her room, there was an Advair and tiotropium bromide monohydrate inhaler on the Resident's bedside table. On [DATE] at 8:41 A.M., the surveyor observed a Certified Nursing Assistant enter and exit Resident #38's room, the surveyor then observed that the Advair and tiotropium bromide monohydrate inhaler remained on the Resident's bedside table. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:00 P.M., Resident #38 said he/she keeps his/her inhalers on the bedside table, that he/she does not have a lock box, and that the drawer in his/her bedside cabinet does not lock. On [DATE] at 7:32 A.M., the surveyor observed Resident #38 sleeping in his/her room, there was an Advair and tiotropium bromide monohydrate inhaler on the Resident's bedside table. During an interview on [DATE] at 7:45 A.M., Certified Nursing Aide (CNA) #1 said she sees inhalers on Resident #38's bedside table every day. During an interview on [DATE] at 7:50 A.M., Nurse #15 said that Resident #38's inhalers should be locked inside the bedside cabinet drawer, and that CNA's should bring inhalers to the nurses if they observe them unsecure. During an interview on [DATE] at 8:05 A.M., the Director of Nursing said Resident #38's inhalers should be stored securely in the Resident's drawer.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 44095 Based on record review, policy review, and interviews, the facility failed to ensure laboratory services were provided for one Resident (#62) out of a sample of 39 residents. Specifically, the facility failed to ensure a 24-Hour urine was obtained. Findings include: Review of the facility policy titled Dialysis Management, dated as revised 10/2022, indicated residents receiving Hemodialysis treatments will be assessed and monitored to ensure quality of life and well-being. 2. The nurse will obtain orders for monitoring of site, and interventions as appropriate. Orders to include: - Lab work as directed by dialysis and/or physician. Review of the facility policy titled Lab - Procedure, dated as revised 1/2023, indicated to provide a means to check a resident's specimen as ordered by the physician and to maintain a record of the results. 1. Obtain a physician's order for all lab work and enter the order into the EMR (electronic medical record). 2. Determine if labs are routine, scheduled, or immediately (STAT) that would require calling lab directly. 3. Fill out the necessary lab slips &/or enter the information into the lab portal system. 5. If deemed necessary, the facility may keep a special log for laboratory tests being ordered. 9. Lab results can be obtained through contracted Lab Companies. Resident #62 was admitted to the facility in February 2024 with diagnoses including chronic kidney disease, diabetes, depression, and obesity. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/8/24, indicated that Resident #62 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #62 required dialysis and he/she was frequently incontinent of urine. Review of Resident #62's physician's order, dated 7/11/24, indicated: - 24-hour (HR) urine sample. Please send the patient to dialysis with it on Thursday, every shift for prophylactic. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's dialysis form, Patient Instructions for Residual Renal Urine Collection, undated, indicated the following: Start Time: 7/12/24, 24 hours before you leave home for your next dialysis treatment. Patient Instruction: STEP 1: At your start time, empty your bladder. Attempt to urinate even if it is just a few drops. Do not save this urine. You are now ready to START the 24-hour urine collection. STEP 2: Save all urine in the collection jug until your stop time. At your stop time, make an attempt to urinate and add this to the jug. You can urinate into a urinal (men) or a urine hat (women) placed in the commode, and then pour that urine into the jug STEP 3: The jug must be kept refrigerated, or in a cooler on ice, until you leave home to bring the jug to dialysis. STEP 4: Bring the collection jug and this instruction record to the dialysis facility when you come for your next treatment. Review of Resident #62's nursing progress notes indicated the following: - 7/12/24: Issue reported to this nurse by night nurse unable to collect 24-hour urine. Has dialysis tomorrow. Review of Resident #62's provider's progress note, dated 7/15/24, indicated the following: - Dialysis is looking to for 24-hour urine. Patient is incontinent of urine. Will confirm with dialysis if foley catheter is appropriate to obtain urine. On 7/23/24 at 7:28 A.M., the surveyor and Nurse #7 observed in the Phillip's unit medication room in the medication refrigerator the following: - one jug (24-hour urine) with liquid in it. Nurse #7 then immediately tossed the jug into the trash and she said she was not sure why there was a urine jug in the medication refrigerator. During an interview on 7/25/24 at 4:00 P.M., Resident #62 said that he/she has returned from dialysis twice with a urine jug. Resident #62 said he/she had provided pee to the nursing staff, but he/she has not been given the jug to bring back with him/her to dialysis. During an interview on 8/1/24 at 8:48 A.M., Certified Nurse Assistant (CNA) #7 said that Resident #62 is continent and incontinent. During an interview on 7/29/24 at 7:11 A.M., Nurse #11 said that she was aware that Resident #62 needed a 24-hour urine for dialysis. Nurse #11 said she was not sure what the status was of the urine. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 4:05 P.M., Nurse #13 said he was aware that Resident #62 required a 24-hour urine for dialysis. Nurse #13 said he had not followed up with the dialysis center for alternative methods of obtaining the 24-hour urine. During an interview on 7/25/24 at 12:58 P.M., the Dialysis Nurse said Resident #62 needs a 24-hour urine. The Dialysis Nurse said that Resident #62 was provided a 24-hour sample jug twice and the nursing home has yet to collect the urine. The Dialysis Nurse said that she has not received outreach from the facility but there are alternative ways to obtain the urine. During an interview on 7/25/24 at 10:08 A.M., Nurse Practitioner #1 said that nursing should have followed up with dialysis center about alternative methods for obtaining the 24-hour urine. During an interview on 7/29/24 at 4:21 P.M., the Director of Nursing said should have obtained the 24-hour urine and implemented an alternative means to obtain the 24-hour urine.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 45763 Based on interview and record review the facility failed to obtain routine and 24-hour emergency dental care for one Resident (#16) out of a total sample of 39 residents. Findings include: Review of the facility policy titled Dental Services, revised October 2022, indicated, but was not limited to, the following: - Both routine and emergency dental services are available to meet the resident's oral health care needs based upon resident assessment and plan of care. - Routine and 24-hour emergency dental services are provided to our residents through: a. A contract agreement with a licensed dentist that comes to the facility monthly; b. Referral to the resident's personal dentist; c. Referral to community dentists; or d. Referral to other health care organizations that provide dental services. - Selected dentist must be available to provide follow-up care. Failure of a dentist to provide follow-up services will result in the facility's right to use its consultant dentist to provide the resident's dental needs. - Identified individuals will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. - All dental services provided are recorded in the resident's medical record. A copy of the residents dental record is provided to any facility to which the resident is transferred. Review of Resident #16's care plans indicated that Resident #16 had oral/dental health problems related to complaint of oral discomfort, with the following intervention: - Refer to dentist, initiated 1/1/24. Review of Resident #16's medical record failed to indicate the Resident had ever been seen by the dentist, or that a consultant dentist consent form had been completed. Review of the consultant procedure history report, dated 7/1/23 through 7/26/24, failed to indicate that Resident #16 was seen by consultant dentist dental services. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 12:09 P.M., the Unit Supervisor said all residents use the consultant dentist for dental services, and that a consultant dentist consent should be completed on admission. The Unit Supervisor said that if a resident had a complaint or issue, they should obtain a consent for the consultant dentist and should then be seen by the dentist who comes to the facility on ce a month. During an interview on 7/29/24 at 4:15 P.M., the Director of Nursing (DON) said if a resident needs to be seen by a dentist the facility will call to arrange an appointment, and that all residents should be seen routinely. The DON said Resident #16 had never been seen by dental services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45763 Based on interviews and record reviews the facility failed to employ a qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. Findings include: Review of the Dietitian job description indicated, but was not limited to, the following: Position summary: -Provides consultation concerning nutritional services to the Administrator of the facility and works in advisory capacity to the Food Service Director in accordance with current generally accepted professional practices. - Provides consultation to allied staff, consultants and physicians regarding diet, nutritional problems and management, including patient visitation, nutritional assessment, patient nutritional care plans, and diet reviews. - Updates nutritional care plans on a timely basis. - Will review diets and nutritional status on residents' chart and make recommendation to the physician for changes as necessary. - Will visit each nurse's station weekly and check with the charge nurse and/or the dietary communication book for any comments and/or dietary concerns on that particular unit. Review of the Facility assessment, updated 5/24/24, indicated the facility required a dietitian for 24 hours a week. Further review of the facility assessment indicated that a dietitian was a necessary resource in managing the following complex medical care: - Neurological system - Neoplasm - Metabolic Disorders - Respiratory System - Genitourinary system - Diseases of Blood - Digestive System (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Integumentary System (skin ulcers, injuries, surgical wounds) - Infectious Diseases - Nutritional Disorder (failure to thrive) - Covid-19 virus During an interview on 7/25/24 at 1:17 P.M., the Registered Dietitian (RD) said that she had started in her role six weeks ago, and that the first two weeks were spent in orientation. The RD said that the last RD had left around last December, and that during the interim there had been nothing in place to compensate for the lack of Dietitian or coverage by consulting Dietitians. The RD said that the Food Service Director does not have the expertise to replace the Dietitian and had not been conducting nutrition assessments. The RD said that there have been assessments that have not been completed in the absence of a Dietitian, and that she would expect the facility to have employed a Dietitian. During an interview on 7/25/24 at 11:32 A.M. the Food Service Director (FSD) said the previous Dietitian had resigned in January and that there were no consulting Dietitians during the interim. The FSD said he had not been completing nutrition assessments or reviewing weights. During an interview on 7/25/24 at 2:41 P.M. the Administrator said that the previous Dietitian had left in January of 2024, and that there had not been a qualified nutrition professional to cover during the interim. The Administrator said that the facility had not employed a Dietitian from 1/18/24 until 6/4/24. During a follow-up interview on 7/31/24 at 7:40 A.M. the Administrator said that Dietitian responsibilities would have been delegated by the Director of Nursing (DON), that the speech therapist would adjust diets, and that the Medical Director and Nurse Practitioner (NP) would be implementing nutrition interventions. During an interview on 7/31/24 at 2:59 P.M., the DON said that nothing had been delegated to her to compensate for the lack of a Dietitian. During an interview on 8/1/24 at 9:17 A.M., NP #1 said there was a period when the facility did not have a Dietitian, which was an issue, and that no additional responsibilities were delegated to her to compensate for the missing Dietitian. During a follow-up interview at 7/31/24 at 8:04 A.M., the Administrator said that he would rely on clinical staff to make him aware of a critical need for a Dietitian, and that cycling Dietitians from other buildings would have to be initiated by the governing body; the Administrator said that Dietitians are currently being cycled in other buildings. The Director of Operations said she had started in April and was aware that the facility did not have a Dietitian. The Director of Operations said that if there was ever a need, and things were dire, that they could cycle a Dietitian from another building owned by the company, but that she didn't feel there was a need. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/1/24 at 1:01 P.M., the Occupational Therapist (OT) said that she was not aware of any additional responsibilities delegated to the therapy department to compensate for the lack of a Dietitian. During an interview on 8/1/24 at 10:18 A.M., the Medical Director said that nothing had changed regarding his practice in the absence of a Dietitian, that typically he would defer to the Dietitian to meet the nutritional needs of residents but in the absence of a Dietitian would defer to weights for monitoring. During an interview on 8/12/24 at 10:05 A.M., the Speech Language Pathologist (SLP) said that she was aware that the facility did not have a Dietitian, but that no additional responsibilities were delegated to her to compensate for the lack of a dietitian.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observations and interviews the facility failed to provide food and drink that was palatable, attractive, and at a safe and appetizing temperature. Findings include: Review of the resident council meeting minutes, dated 4/30/24, indicated that food and coffee was being served to residents cold. Review of the resident council meeting minutes, dated 5/28/24, indicated that food was always cold, and sometimes the coffee was as well. Further review of the resident council minutes indicated that most sandwiches were either soggy, or hard and old. Review of the resident council meeting minutes, dated 6/25/24, indicated that the sandwiches were wet, and that food was still arriving cold. Further review of the resident council minutes indicated that breads are often burnt or undercooked, and that the residents requested real eggs because the liquid eggs taste bad; a lot of complaints of stale breads/sandwiches or burnt/overcooked breads. During initial screening on 7/23/24 residents made the following complaints regarding food: -I tell staff I'm used to human food and won't eat theirs because it is dog food, and they laugh. -Food is terrible. -I don't eat because the food is not good regarding taste and temperature and I don't eat any, I think I've lost weight it's so bad. -The toast is not toast, it's warm bread. -The food is not good; I have lots of my own snacks. Toast is warm bread it's not even toasted. -The food is not good; I don't like the taste and order food from outside the facility frequently. -Resident council meets once a month and discuss the same problems including food, which has been unresolved. The Food Service Director (FSD) is invited but doesn't come because he doesn't want to hear our problems. -Food is not the greatest. During the tray line observation on 7/24/24 at 7:30 A.M., the surveyor observed milk and juices being held at room temperature without refrigeration or ice. On 7/24/24 at 8:00 A.M. the surveyor observed the cook saying that the eggs were watery all the time, and that there was nothing that she could do about it. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 8:08 A.M., the [NAME] unit breakfast food truck arrived to the resident care unit. After all resident trays were served the surveyor received the test tray at 8:19 A.M., and the following was recorded and observed: - Scrambled eggs were 134.5 degrees Fahrenheit, tasted bland, and appeared pale in color. - Toast was 118 degrees was tough/rubbery and soggy; the toast tasted cool/room temperature. - Coffee was 142 degrees and tasted bitter. - Milk was 51 degrees Fahrenheit. - Juice was 64 degrees Fahrenheit and tasted room temperature not cold; the test tray was received 49 minutes after the surveyor observed the same drinks being held at room temperature in the kitchen for service. On 7/24/24 at 8:20 A.M., the [NAME] unit breakfast food truck arrived to the resident care unit. After all resident trays were served the surveyor received the test tray at 8:30 A.M., and the following was recorded and observed: - Scrambled eggs were 108.4 degrees Fahrenheit. - Toast was 94.5 degrees Fahrenheit, was rubbery, and tasted barely warm. - Milk was 53.9 degrees Fahrenheit and tasted cool, not cold. - Juice was 62.8 degrees Fahrenheit and tasted room temperature, not cold; the test tray was received one hour after the surveyor observed the same drinks being held at room temperature in the kitchen for service. On 7/24/24 at 8:33 A.M., the [NAME] unit breakfast food truck arrived to the resident care unit. After all resident trays were served the surveyor received the test tray at 8:49 A.M., and the following was recorded and observed: - Scrambled eggs were 113 degrees Fahrenheit. - Toast was 92 degrees Fahrenheit, the toast was soft and gummy. - Oatmeal was 149 degrees Fahrenheit. - Juice was 62.5 degrees Fahrenheit and tasted room temperature not cold - Milk was 55.5 degrees Fahrenheit and tasted cool not cold; the test tray was received an hour and 19 minutes after the surveyor observed the same drinks being held at room temperature in the kitchen for service. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 12:33 P.M., the [NAME] unit lunch food truck arrived to the resident care unit. After all resident trays were served the surveyor received the test tray at 12:37 P.M., and the following was recorded and observed: - Beef and noodles were 148.1 degrees Fahrenheit and tasted salty, the noodles were oily and had a mushy texture consistent with overcooking. - Carrots were 136 degrees Fahrenheit and tasted luke warm not hot. - Milk was 49 degrees Fahrenheit. - Peaches were 53 degrees Fahrenheit. On 7/25/24 the [NAME] unit lunch food truck arrived to the resident care unit. After all resident trays were served the surveyor received the test tray at 12:41 P.M., and the following was recorded and observed: - Beef and noodles were 144 degrees Fahrenheit, the gravy was beginning to separate; noodles were without flavor and had a mushy texture consistent with overcooking. - Carrots were 129 degrees Fahrenheit and tasted warm, not hot. - Peaches were 52 degrees Fahrenheit. - Milk was 53.8 degrees Fahrenheit. On 7/25/24 at 12:44 P.M., the [NAME] unit lunch food truck arrived to the resident care unit. After all resident trays were served the surveyor received the test tray at 12:55 P.M., and the following was recorded and observed: - Beef and noodles were 138 degrees Fahrenheit and tasted warm, not hot, the noodles had a mushy texture consistent with overcooking. - Carrots were 117 degrees Fahrenheit and tasted warm not hot. - Peaches were 55 degrees Fahrenheit and tasted cool not cold. - Milk was 55 degrees Fahrenheit and tasted cool not cold. During an interview on 7/30/24 at 2:09 P.M., the FSD said that he wasn't aware of resident complaints regarding food until recently, and that he hadn't been conducting test trays. The FSD said he would expect hot food to be served above 130 degrees Fahrenheit, and cold food below 45 degrees Fahrenheit.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 44095 Based on observations, policy review, record review, and interviews the facility failed to ensure one Resident (#24) out of a total sample of 39 residents, was provided the therapeutic diet in accordance with physician orders. Specifically, Resident #24 was not provided with his/her diet as ordered by the physician. Findings include: Review of the policy titled Meal Tray Identification, dated as revised 1/2023, indicated that there will be a means of identifying resident meals and trays for therapeutic requirements and resident preferences. 1. Nursing conveys the following admission information to Dining Services. - Diet order. 2. Food service Manager or designee enters above information into Resident Meal program. 4. Resident food preferences are obtained and entered into Resident Meal Program. 5. Tickets are used to identify correct items for resident diet. Resident #24 was admitted to the facility in August 2022 with diagnoses including multiple sclerosis, quadriplegia, dyspepsia, and protein malnutrition. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/21/24, indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS indicated Resident #24 required a therapeutic diet. On 7/23/24 at 8:10 A.M., 7/23/24 at 12:10 P.M., 7/25/24 at 8:34 A.M., 7/25/24 at 11:54 A.M., and on 7/26/24 at 12:31 P.M., the surveyor observed Resident #24 being fed by a Certified Nurse Assistant (CNA) a puree diet. During an interview on 7/25/24 at 8:34 A.M., Resident #24 said he/she did not like the puree eggs, and he/she continued to say he/she was not sure why the eggs were now pureed. During an interview on 7/31/24 at 8:24 A.M., Certified Nursing Assistant (CNA) #1 said that Resident #24 has been eating a puree diet for about 6 months. CNA #1 said that Resident #24 does not like the pureed eggs. Review of Resident #24's physician's order, dated 5/3/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No Added Salt (NAS) diet, mechanical soft texture, thin liquids consistency, sodium restriction, high protein, and low fat. Review of the dietary manager system (dining tray system), indicated on 5/23/24, Resident #24's diet was changed in the system to puree. Review of Resident #24's dietician's note, dated 6/30/24, indicated: - Resident on no added salt (NAS), mechanical soft, thin liquids with good oral intake. No issues chewing or swallowing current diet texture. Review of Resident #24's diet slip, dated as current on 7/30/24, indicated the following: - NAS Pureed. Further review of the diet slip failed to include the physician's order for mechanical soft texture, high protein, and low fat. During an interview on 7/31/24 at 8:02 A.M., Nurse #7 said that Resident #24's diet slip does not match his/her physician's order. During an interview on 7/31/24 at 4:34 P.M., Nurse #17 said that she obtained the diet order from the discharge summary. Nurse #17 said that she notified the kitchen by diet change slip. During an interview on 7/30/24 at 11:08 A.M., the Food Service Director (FSD) reviewed Resident #24's diet order and said that the order in the electronic health record did not match the diet on the diet slip. The FSD said a low-fat diet would be heart healthy according to the diet manual. The FSD said that high protein was not on the diet slip. During an interview on 7/30/24 at 1:53 P.M., the Dietitian said that Resident #24's diet order in the electronic health record should match the dietary manager system order but did not. During an interview on 7/31/24 at 11:52 A.M., the Director of Nursing said Resident #24's diet should match the physician's order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44095 ready for final edit- please delete once done Based on observations, record review, policy review, and interviews, for one Resident (#51) of 39 sampled residents, the facility failed to provide adaptive equipment. Specifically, the facility failed to ensure Resident #51 was consistently provided with a lip plate and sippy cups for use during his/her meals to maximize food intake. Findings include: Review of the policy, Adaptive Equipment, dated as created 10/2022, indicated in order to protect the safety and well-being of residents, and to promote quality care, this facility uses appropriate techniques and devices to enhance the residents dining experience. To ensure all dietetic equipment/ utensils are used appropriately and are well maintained. - Using the Dietary change form, the Dietary Department is informed of any new recommendation from the Speech Pathologist or Occupational Therapy. Dietary: 1. Ensures the device is on the resident's tray at every meal. Nursing: 1. Ensure staff are aware that residents should be using the device - Place on CNA task and update care plan. 2. Ensures the device is on the resident's tray at every meal. Resident #51 was admitted to the facility in February 2017 with diagnoses including dementia, glaucoma, contracture of the right hand, and dysphagia. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/6/24, indicated that Resident #51 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS indicated Resident #51 required supervision/ touching assistance with eating. Review of Resident #51's physician's orders, dated 11/27/17, indicated: - lip plate for all meals - aspiration precautions Review of Resident #51's physician's order, dated 7/5/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Skilled Occupational Therapy (OT) Clarification Order: Provide adaptive equipment (AE) - 2 handled sippy cup with lid and lip plate during each meal in order to maximize functional performance with activities of daily living (ADL)-self-feeding task, effective 7/4/24. On 7/23/24 at 12:10 P.M. the surveyor observed Resident #51 eating with a regular plate he/she had pushed raviolis off the far side of his/her plate. There was no sippy cup on his/her tray. On 7/24/24 at 8:18 A.M. the surveyor observed a Certified Nursing Assistant (CNA) deliver Resident #51 his/her breakfast tray. There was one sippy cup on the tray, with 4 different liquids in regular cups. During an on 7/24/24 at 8:45 A.M., Resident #51 asked the surveyor to rinse out his/her sippy cup and fill the sippy cup with hot chocolate, I can't drink the hot chocolate unless it's in the cup, I wish I had more than one cup. On 7/24/24 at 8:54 A.M., the surveyor observed a CNA enter Resident #51's room, the CNA said that Resident #51 should have at least two sippy cups so he/she can have a choice of drink. On 7/25/24 at 8:20 A.M., the surveyor observed Resident #51 [NAME] at a donut with a fork on a regular plate, the surveyor observed a donut piece that had fallen off the plate on the far side of plate out of reach. There was no lip plate. On 7/25/24 at 12:47 P.M., the surveyor observed Resident #51 eating beef with noodles; the noodles and carrots were pushed off the far side of plate. There was no lip plate. On 7/26/24 at 12:31 P.M., the surveyor observed that Resident #51 did not have a lip plate. Resident #51 was eating fish and peas that were pushed off the far side of the plate. On 7/29/24 at 8:31 A.M., the surveyor observed that Resident #51 was not provided a lip plate and was not provided a sippy cup. Resident #51 was eating cut up sausage and there were sausage pieces pushed off the far side of the plate. During an interview on 7/30/24 at 7:12 A.M., Certified Nursing Assistant #1 said Resident #51, doesn't have a lip plate and he/she needs more than one sippy cup for his/her meals. During an interview on 7/31/24 at 8:00 A.M., Nurse #7 said Resident #51 should provide the lip plate from the kitchen, Nurse #7 said she wasn't aware of the most recent recommendation. During an interview on 8/1/24 at 4:24 P.M., Nurse #13 said he was not aware that Resident #51 required a lip plate and a sippy cup. During an interview on 8/1/24 at 12:57 P.M., the Occupational Therapist said that he/she did an evaluation on Resident #51 on 7/4/24 and recommended the sippy cup and the lip plate. The OT said she completed a dietary slip for the adaptive equipment and sent the slip to the kitchen. During an interview on 7/30/24 at 8:03 A.M., the Food Service Director (FSD) said he was not aware that Resident #51 required a lip plate. The FSD said that the sippy cups should be supplied on the tray. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/24 at 4:04 P.M., the Director of Nursing said nursing should implement the physician orders and the occupational therapist recommendation and provide Resident #51 with the lip plate and sippy cup.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763 Based on observation, policy review, and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure food was labeled, that employees did not store their drinks with resident food/ingredients, that staff discarded produce with visible signs of decomposition, that staff discarded dairy products that were past their expiration date, and that food was not stored on the floor. Findings include: Review of the current FDA (Food and Drug Administration) food code indicated the following: - food shall be protected from contamination by storing the food: 1) In a clean, dry location; 2) Where it is not exposed to splash, dust, or other contamination; and 3) At least 15 cm (6 inches) above the floor. Review of the facility's undated policy titled Food Storage (Dry, Refrigerated, and Frozen), indicated, but was not limited to, the following: - All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. - Rotate products so the oldest are used first. Staff shall be instructed to use products with the earliest expiration date before those with later expirations dates. - Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. - Leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and/or freezers. On 7/23/24 at 6:53 A.M., the surveyor made the following observations during the initial walkthrough of the kitchen: -A water bottle containing a brown liquid in the reach-in refrigerator, stored with resident food and ingredients. -An avocado with significant color and textural signs of decomposition in the reach-in refrigerator. -Three bowls containing cottage cheese, wrapped but undated in the reach-in refrigerator. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A container of brown liquid, dated 12/25/23 in the reach-in refrigerator. -A container containing a creamy dressing, undated in the reach-in refrigerator. -An open package of ham wrapped but undated in the walk-in refrigerator. -An open package of cheese wrapped but undated in the walk-in refrigerator. -A tomato with significant color and textural signs of decomposition in the walk-in refrigerator. -Two bags of shredded cheese, opened but undated in the walk-in refrigerator. -Spinach and fire-roasted pepper onion blend in a crate stored directly on the floor in the walk-in freezer. -Peas in a crate stored directly on the floor in the walk-in freezer. -A box of chicken, stored directly on the floor under a shelf in the walk-in freezer. On 7/23/24 at approximately 7:20 A.M., the surveyor made the following observations on the first-floor kitchenette: - Chocolate milk with 1/3rd of the bottle remaining opened with an expiration date of 7/22/24. - A carton of milk with an expiration date of 7/16/24 On 7/23/24 at approximately 7:30 A.M., the surveyor made the following observations on a second-floor kitchenette: - Orange mango [NAME] juice opened and almost completely depleted but undated. - Two daily probiotic dairy drinks with expiration dates of 7/3/24. During an interview on 7/23/24 at 6:57 A.M., the Food Service Director (FSD) said that the water bottle with brown liquid belonged to a staff member and should not have been stored with resident food. The FSD said everything should be labeled and dated once prepared or opened, and the avocado should have been discarded. The FSD said the cottage cheese should have been labeled and dated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45763 Based on observations and interviews the facility failed to ensure it was administered in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically: 1.) The facility failed to provide nursing staff education and training to provide competent, safe, and effective wound care management. As a result the facility failed to notify the physician, implement treatments recommended by the consulting wound physician, assess the nutritional status and implement pertinent nutrition interventions for a Resident (#85) resulting in a new necrotic skin condition progressing to an unstageable wound leading to osteomyelitis (a bone infection), significant weight loss, and sepsis (a life-threatening response to infection) requiring hospitalization and need for a fecal-diverting colostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, that allows digested food to pass out of the body through an external pouch system). 2.) The facility failed to allocate resources to meet the nutritional needs of residents in the absence of a Dietitian. Findings include: 1.) According to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the Facility Assessment Tool, dated 5/24/24, included but was not limited to the following: - Commonly admitted diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management: Integumentary System: Skin Ulcers, Injuries, surgical wounds. Facility utilizes Wound Physicians: MD/NP, Nursing, Registered Dietician, regularly scheduled skin Assessments, Wound care supplies, Consultation with specialist as needed for wound management. - Services and Care we offer based on our Resident's Needs: Skin Integrity: Pressure injury prevention and care, skin care, wound care, (surgical, other skin wounds). - Staff training/education and competencies: Competencies by department. - Licensed Nurses Annual Competencies: Treatment Administration, Colostomy Care. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	- Licensed Nurses Competencies on hire and PRN: Transcribing order, Skin Prevention/Wound Program. - Certified Nurse Assistant (CNA) Annual Competencies: Preventative skin care. Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. Review of Resident #85's Skin Only Evaluation, dated 3/11/24, indicated Resident #85 had a new necrotic (the death of body tissue or an organ due to a lack of blood supply) wound on the left buttock, medial area, and that the wound did not have an odor. Review of Resident #85's initial Wound Evaluation and Management Summary, dated 3/12/24, indicated the Wound Physician evaluated the Resident for a rash. The Wound Physician diagnosed Resident #85 with diaper dermatitis and recommended lotrisone cream (an anti-fungal cream) to be applied twice daily to the affected area and prn (as needed). Review of Resident #85's Treatment Administration Records failed to indicate that the lotrisone cream was implemented. During an interview on 7/29/24 at 10:03 A.M., Nurse #17 said that when changes in skin are identified they should be reported to the NP (Nurse Practitioner)/MD (medical doctor). Nurse #17 said that the Wound Physician will give recommendations to the staff member accompanying her during wound rounds every Tuesday. Nurse #17 said that a Certified Nursing Assistant had initially reported the wound to her, and that the Resident had a wound on the left buttock, medical area; Nurse #17 said she had not reported the wound to the physician because the wound did not need the physicians' attention because of how small it was. Nurse #17 said aides had been using house barrier cream to Resident #85 buttocks region, which was not a new treatment for the newly identified wound in March. During an interview on 7/30/24 at 11:13 A.M., The Wound Physician said she was initially consulted on 3/12/24 to evaluate a rash on Resident #85's frontal groin area, and nothing else; as the rash was on the front she may not have evaluated the backside and she was not aware of a necrotic wound when she evaluated the rash. The Wound Physician said this may have been a result of bad communication. Review of the communication book and Resident #85's progress notes failed to indicate that the physician was notified of the new necrotic skin condition identified on 3/11/24. Review of Resident #85's entire medical record indicated a wound treatment was not ordered until 3/23/24, 12 days after Nurse #17 had initially identified the necrotic wound. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Following this initial failure to notify the physician of the change in condition (the new necrotic skin condition), failure to implement wound care recommendations for a skin condition, failure to notify the physician of the wound care recommendations, and failure to transcribe the physician's orders related to wound care, there continued to be repeated failures, including, but not limited to: - On 3/26/24, the Wound Physician recommended alginate calcium (a gel that promotes wound healing), and santyl (an ointment used to promote the healing of skin ulcers by removing damaged tissue) for Resident #85's unstageable sacral ulcer. The physician's orders for alginate calcium and santyl were never implemented before Resident #85 was emergently hospitalized on [DATE]. Review Resident #85's hospital paperwork, dated 4/22/24, indicated he/she was admitted with a diagnosis of sepsis with the presumed source the infected sacral ulcer. Resident #85 underwent wound debridement (a procedure that removes unhealthy or dead tissue from a wound to promote healing and prevent infection) on 3/29/24, 3/31/24, 4/5/24, and 4/21/24, and that fecal diversion was indicated to allow for the wound to heal due to the wound's proximity to the anus; and on 4/5/24 the Resident underwent a diverting loop sigmoid colostomy creation. The hospital paperwork indicated there was clinical and imaging evidence of osteomyelitis with the sacrum/coccyx bones exposed in the wound. - On 3/26/24, the Wound Physician recommended a house supplement (a calorically and nutritionally fortified drink typically utilized to address weight loss and/or meet assist in meeting nutrient, such as protein, needs). This house supplement continued to be documented in Wound Physician written recommendations on 4/23/24, 4/30/24, 5/14/24, 5/21/24, 6/4/24, and 7/23/24. This house supplement was never implemented. - On 4/23/24, the Wound Physician recommended negative pressure wound therapy (wound vac) to be applied and to be changed three times per week for 30 days at 125 mmHg (millimeter of mercury, a manometric unit of pressure) continuously, the nurses failed to transcribe the order for the correct frequency. The Wound Physician continued to document written recommendations to have the wound vac changed three times a week on 4/23/24, 4/30/34, and 5/14/24. As a result, the nurses only changed the wound vac two times a week (instead of three times a week) since it was initially applied on 4/23/24. This wound vac was never changed at the correctly ordered frequency. - On 4/23/24, the Wound Physician recommended a foley catheter (a medical device that helps drain urine from the bladder) as urine will cause wound vac to lose suction. A foley catheter was not implemented until 7/11/24, 80 days after the Wound Physician initially recommended the placement of a foley catheter. During an interview on 7/31/24 at 3:58 P.M., Nurse #17 said she was the nurse who first identified Resident #85's new necrotic area. Nurse #17 said she never had any wound competencies completed at the facility since she was hired on 9/29/22. The surveyor reviewed Nurse #17's education file which failed to indicate any evidence of the required competencies for skin prevention/wound program, treatment administration, transcribing orders, change in condition, or communication. During an interview on 7/31/24 at 7:39 A.M., Nurse #2 said she never had any wound competencies completed at the facility since she was hired on 3/8/24. Nurse #2 said she never had any competencies completed since she was hired, including topics such as treatment administration, transcribing orders, skin prevention/wound program, change in condition, or communication. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The surveyor requested staff education files with all competencies for 5 Certified Nurse Assistants (CNA) and 12 Licensed Nurses on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 12 Licensed Nurses education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 12 Licensed Nurses had competencies completed for skin prevention/wound program - 0 out of 12 Licensed Nurses had competencies completed for transcribing orders. - 0 out of 12 Licensed Nurses had competencies completed for treatment administration - 0 out of 12 Licensed Nurses had competencies completed for colostomy care. - 0 out of 12 Licensed Nurses had competencies completed for change in condition. - 0 out of 12 Licensed Nurses had competencies completed for communication. Review of 5 Certified Nurse Assistant (CNA) education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 5 CNA's had competencies completed for preventative skin care. 2.) Further review of the Facility Assessment Tool indicated the facility required a dietitian for 24 hours a week and that a dietitian was a necessary resource in managing the following complex medical care: - Integumentary System (skin ulcers, injuries, surgical wounds) - Nutritional Disorder (failure to thrive)Neurological system - Neoplasm - Metabolic Disorders - Respiratory System - Genitourinary system - Diseases of Blood - Digestive System - Infectious Diseases - Covid-19 virus (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Dietitian job description indicated, but was not limited to, the following: Position summary: -Provides consultation concerning nutritional services to the Administrator of the facility and works in advisory capacity to the Food Service Director in accordance with current generally accepted professional practices. - Provides consultation to allied staff, consultants and physicians regarding diet, nutritional problems, and management, including patient visitation, nutritional assessment, patient nutritional care plans, and diet reviews. - Updates nutritional care plans on a timely basis. - Will review diets and nutritional status on residents' chart and make recommendation to the physician for changes as necessary. - Will visit each nurse's station weekly and check with the charge nurse and/or the dietary communication book for any comments and/or dietary concerns on that particular unit. Resident #85 was admitted to the facility in March 2023 with diagnoses including Alzheimer's Disease, cerebral infarction, diabetes, hemiplegia (muscle weakness or paralysis on one side of the body that can affect arms, legs, and facial muscles), and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment, dated 2/27/24, indicated that Resident #85 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 did not have any pressure ulcers but was at risk for developing pressure ulcers. Review of Resident #85's weight and vitals summary indicated the following weight readings: 3/7/23 - 199.3 lbs. 6/19/23 - 204 lbs. 11/14/23 - 203.4 lbs. 2/2/24 - 200.4 lbs. 3/7/24 - 200.8 lbs. 4/22/24 - 189 lbs. 5/14/24 - 185.4 lbs. 7/20/24 - 141 lbs. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Certified Nursing Assistant (CNA) assignment sheet, dated 6/3/24, indicated Resident #85 weighed 181.2 lbs. Further review of Resident #85's recorded weights indicated that Resident #85 had lost 11.8 lbs. of body weight during hospitalization between 3/7/24 and 4/22/234, and then continued to lose weight. Review of the recorded weights indicated that Resident #85's weight loss reached clinical significance on 5/14/24, indicating the Resident had lost a total of 7.6% of his/her total body weight within 2 months. The weight recorded in the CNA assignment book confirms a trend of weight loss, and review of the weight records indicated the Resident had lost an additional 40 lbs. of body weight on 7/20/24, indicating an additional, clinical significant loss of 22.2% of his/her total body weight lost in a month, 25.4% of his/her total body weight lost in three months, or 29.2% of his/her total body weight lost in six months. Review of Resident #85's recorded weights failed to indicate that a reweight was obtained for the weight taken on 4/22/24 until 22 days later, for the weight taken on 5/14/24 until 20 days later, for the weight taken on 6/3/34 until 47 days later, and that a reweight was never obtained to confirm the weight reading on 7/20/24. Review of Resident #85's medical record indicated the Resident was hospitalized again on 5/9/24, 5/22/24, and 7/10/24 for wound-related reasons. Review of the hospital discharge paperwork, dated 5/9/24, indicated the Resident met criteria for severe calorie-protein malnutrition, required enteral nutrition via a nasogastric tube (a tube placed through the nose terminating directly in the stomach used to provide nutrition formula) during the hospitalization, and the hospital recommended to continue supplemental nutrition at the long-term care facility. Review of the hospital discharge paperwork, dated 7/10/24, indicated the Resident appeared cachectic and that the Resident had presented with severe sepsis secondary to his/her sacral wound requiring admission to the ICU (intensive care unit). Further review of Resident #85's medical record failed to indicate any nutritional evaluation or recommendations/orders were implemented for the Resident. Review of Resident #85's medical record indicated he/she was evaluated by the Registered Dietitian (RD) on 7/1/24, 112 days after the necrotic skin condition was first identified, and 48 days after Resident #85's weight loss reached clinical significance. Review of the RD's progress note, dated 7/1/24, indicated the Resident had lost weight and recommended Proheal (a liquid protein supplement) 30cc tid (three times a day) (providing 45 gm elemental protein), Vitamin C 500mg bid, Zinc 220mg x 30 days, and weekly weights. Review of the most recent Wound Evaluation and Management Summary, dated 7/23/24, indicated that Resident #85 had a stage IV pressure wound measuring 16 x 15.5 x 4.8 cm, and that the wound was not at goal; the Wound Physician recommended house supplements. Review of the Minimum Data Set (MDS), dated [DATE], indicated that Resident #85 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severe cognitive impairment. Further review of the MDS indicated that Resident #85 was at risk for developing pressure ulcers and that the Resident had an unhealed Stage IV pressure ulcer. On 7/30/24 at 8:01 A.M., the surveyor observed the Wound Physician and the Unit Supervisor performing wound care on Resident #85. The wound was larger in diameter than a cantaloupe with a bright red wound bed and some yellow-colored tissue. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #85's medical record indicated that the Wound Physician recommended house supplements on 3/12/24, 3/19/24, 3/26/24, 4/23/24, 4/30/24, 5/14/24, 5/21/24, 5/28/24, 6/4/24, 6/11/24, 6/18/24, 6/25/24, 7/2/24, 7/9/24 and 7/23/24. Review of Resident #85's physician orders, dining manager change history report, and care plans failed to indicate that any nutrition interventions were ever initiated for Resident #85, including the house shakes recommended by the Wound Physician or the Proheal, Vitamin C, Zinc, and weekly weights recommended by the RD. During an interview on 7/25/24 at 1:17 P.M., the Registered Dietitian (RD) said that she had started in her role six weeks ago, and that the first two weeks were spent in orientation. The RD said that the last RD had left around last December, and that during the interim there had been nothing in place to compensate, and no consulting Dietitians. The RD said that the Food Service Director does not have the expertise to replace the Dietitian and had not been conducting nutrition assessments. The RD said that there have been some assessments that have not been done in the absence of a Dietitian, and that she would expect the facility to have employed a Dietitian. The RD said she had initially agreed to work 10 hours a week but would need more hours than that. During an interview on 7/25/24 at 11:32 A.M. the Food Service Director (FSD) said the previous Dietitian had resigned in January and that there were no consulting Dietitians during the interim. The FSD said he had not been completing nutrition assessments or reviewing weights. During an interview on 7/25/24 at 2:41 P.M. the Administrator said that the previous Dietitian had left in January of 2024, and that there had not been a qualified nutrition professional to cover during the interim. The Administrator said that the facility had not employed a Dietitian from 1/18/24 until 6/4/24. During a follow-up interview on 7/31/24 at 7:40 A.M. the Administrator said that Dietitian responsibilities would have been delegated by the Director of Nursing (DON), that the speech therapist would adjust diets, and that the medical director and Nurse Practitioner (NP) would be implementing nutrition interventions. During an interview on 7/31/24 at 2:59 P.M., the DON said that nothing had been delegated to her to compensate for the lack of a Dietitian. During an interview on 8/1/24 at 9:17 A.M., NP #1 said there was a time when the facility did not have a Dietitian, which was an issue. During a follow-up interview at 7/31/24 at 8:04 A.M., the Administrator said that he would rely on clinical staff to make him aware of a critical need for a Dietitian. During a follow-up interview on 8/1/24 at 9:17 A.M. NP #1 said that no additional responsibilities were delegated to her to compensate for the missing Dietitian. During an interview on 8/1/24 at 1:01 P.M., the Occupational Therapist (OT) said that she was not aware of any additional responsibilities delegated to the therapy department to compensate for the lack of a Dietitian. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/1/24 at 10:18 A.M., the Medical Director said that nothing had changed regarding his practice in the absence of a Dietitian, that typically he would defer to the Dietitian to meet the nutritional needs of residents but in the absence of a Dietitian would defer to weights for monitoring. During an interview on 8/12/24 at 10:05 A.M., the Speech Language Pathologist (SLP) said that she was aware that the facility did not have a Dietitian, but that no additional responsibilities were delegated to her to compensate for the lack of a dietitian. During an interview on 8/12/24 at 10:05 A.M., the Regional Director of Operations said that a contract has been in place for clinical consulting since January 1, 2024 but has not been utilized at the facility. She said that it could have been utilized if the Director of Nursing or Administrator brought concerns within the center forward to regional directors- they would have had the ability to bring a consultant in but no concerns were brought forward until this survey. She said she would have expected the facility administration and clinical leadership to recognize and bring forward concerns. Review of the consulting agreement, with an effective date of January 1, 2024 and an end date of December 31, 2026, indicated an agreement between the governing body and a consultant. Further review of the agreement indicated that the consultant duties included consulting services related to the clinical, operations, and regulatory matters related to the operation of the Facilities, as requested by the governing body. 48990 refer to F940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 44095 Based on interview, record review and the Facility Assessment, the facility failed to ensure the Governing Body provided oversight and accountability for effective operational management and quality of care related to the clinical status of residents. Specifically: 1.) The governing body failed to ensure the facility provided consistent and effective nursing staff education and training to provide competent quality of care and effective wound care management, as per the Facility Assessment. 2.) The governing body failed to allocate resources and obtain a Dietitian for the facility, as per the Facility Assessment. Findings include: Review of the facility policy titled, Governing Body, dated as initiated 11/2017, indicated to ensure that the facility has an active (engaged and involved) governing body that is responsible for establishing and implementing policies regarding the management of the facility. Governing Body Members include: Regional VP (vice president) of Operations, Administrator, Assistant Administrator (if applicable), Director of Nursing, Assistant Director of Nursing (if applicable), Quality Assurance Nurse (if applicable). Administrator and/or designee will communicate day to day operation information to the Regional VP of Operations. Day to Day operation information may include survey results, abuse & neglect allegations, complaint surveys. Review of the facility policy titled, QAPI Plan, dated as reviewed 2/18/22, included but was not limited to the following: - (The Company) shall ensure that the Governing Body, Administration, Medical Director, Director of Nursing, clinical and non-clinical staff demonstrate a consistent endeavor to deliver safe, effective, optimal resident care and services in an environment of minimal risk. - This facility shall develop, implement, and maintain an effective, comprehensive, data-driven Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life. - As resident care is a coordinated and collaborative effort, the approach to improving performance shall involve multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the performance improvement activities at this facility. Organization: - To achieve fulfillment of the objectives, goals and scope of the organizational Performance Improvement Plan, the organizational structure of the program shall be designed to facilitate an effective system of monitoring, assessment and evaluation of the care and services provided throughout the facility. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The Governing Body shall be responsible for the quality of resident care provided. - The Governing Body shall require quality assurance and performance improvement mandatory training that outlines and informs staff of the elements and goals of the facility's Performance Improvement Program. - The Governing Body shall set clear expectations around safety, quality, rights, choice, and respect. - The Governing Body shall require the Medical Director to implement and report on the activities and the mechanisms for monitoring, assessing, and evaluating resident safety practices and the quality of resident care, for identifying and resolving problems and for identifying opportunities to improve resident care and services or performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect effect on resident care, including management, administrative functions, and contracted services. 1.) During an interview on 7/31/24 at 11:10 A.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said all nursing competencies were not being completed because they had trouble filling the Staff Development Nurse position. The DON and ADON said they knew these should have been done, but they had not had the time or resources. The DON and ADON further said that the position had been vacant for a long time and then had multiple turnovers recently. Review of the Facility Assessment Tool, dated 5/24/24, included but was not limited to the following: - Facility utilizes wound physicians: MD (medical doctor)/NP (nurse practitioner), nursing, registered dietician, regularly scheduled skin assessments, wound care supplies, consultation with specialist as needed for wound management. - Services and Care we Offer based on our Resident's Needs: Skin Integrity: Pressure injury prevention and care, skin care, wound care, (surgical, other skin wounds). - Staff training/education and competencies: - Licensed Nurses Competencies on hire and PRN (as needed): Skin Prevention/Wound Program, Transcribing order, Change in Condition, Communication, Treatment Administration, weights, and nutritional program. - Certified Nurse Assistant (CNA) Annual Competencies: Preventative skin care. During the survey the survey team identified 5 Residents (#85, #24, #88, #103, and #3) with concerns including the failure to implement wound care recommendations, notify the physician of wound care recommendations, and the failure to transcribe the physician's orders related to wound care. Review of 12 Licensed Nurse education files indicated the following competencies completed as applicable on hire, annually, or as needed: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 0 out of 12, Licensed Nurses had competencies completed for skin prevention/wound, competencies completed for transcribing orders, competencies completed for treatment administration, competencies completed for change in condition, competencies completed for communication, competencies for weights and the nutritional program. Review of 5 Certified Nurse Assistant (CNA) education files indicated the following competencies completed as applicable on hire, annually, or as needed: - 0 out of 5 CNAs had competencies completed for preventative skin care and weights. During an interview on 8/1/24 at 1:01 P.M., Nurse #19 said she used to be the Staff Development Nurse a few months ago. Nurse #19 said nursing competencies were not being completed for Nurses or CNA's. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse said she just started the position a week prior to the start of survey, and she said she had worked in the facility as the MDS Nurse prior. The Staff Development Nurse said nursing competencies haven't been completed in years. The Staff Development Nurse said she knew these should have been done, but they had not had the time or a consistent person in the position. Review of the Staff Development role indicated between January, 2024 to present, the facility had 6 different individuals covering the responsibilities. During an interview on 8/12/24 at 10:05 A.M., the Regional Director of Operations (Governing Body, representative), said that a contract has been in place for clinical consulting since January 1, 2024, but has not been utilized at the facility. During an interview on 8/20/24 at 12:19 P.M., the Director of Nursing (DON) said that she started in January of 2024 and that she had clinical support who called and hired her, and she said she never saw that person in the facility. The DON continued to say there was a new Regional Clinical Director who started back a few months ago but she has not been to the facility. The DON said that she has been without a stable Staff Development Nurse to complete competencies with facility staff and she could have used help. During an interview on 8/21/24 at 1:22 P.M., the Regional Clinical Director said that she provided clinical oversight to the Director of Nursing, and she was in the facility on 5/16/24, 5/20/24, 6/5/24, 6/12/24, 6/24/24, 6/26/24, and 7/3/24. The Regional Clinical Director said she would attend Medicare meetings and review reportable events. The Regional Clinical Director said she was aware of the facilities need for a Staff Development Nurse. Review of the consulting agreement, with an effective date of January 1, 2024, and an end date of December 31, 2026, indicated an agreement between the governing body and a consultant. Further review of the agreement indicated that the consultant duties included consulting services related to the clinical, operations, and regulatory matters related to the operation of the Facilities, as requested by the governing body. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the job description titled, Regional Director of Clinical Services, undated, included but not limited to the following: the Regional Director of Clinical Services (RDCS) will be responsible for assessment and evaluation of clinical services in an assigned geographic service region of the corporation. The RDCS will provide routine consultation services to the facilities in the assigned region. Consultation services include, but not limited to, the areas of resident care, state and federal surveys, regulator compliance, staffing and, MDS reimbursement or case management issues, and clinical services. The RDCS is responsible for driving clinical outcomes, mentoring staff, implementing corporate clinical services policies and procedures and ensuring compliance with state and federal laws, rules and regulations. The RDCS will occasionally be assigned to function as the interim Director of Nursing (DON) in a local facility in times of transition or on an as needed basis short term basis by the VP of Clinical Operations. Review of the job description failed to indicate scope and frequency of visits. 2.) Review of the Facility assessment, updated 5/24/24, indicated the facility required a dietitian for 24 hours a week. Further review of the facility assessment indicated that a dietitian was a necessary resource in managing the following complex medical including: - Integumentary System (skin ulcers, injuries, surgical wounds) - Nutritional Disorder (failure to thrive) Neurological system During the recertification survey there were seven Residents (#85, #68, #16, #24, #42, #50, and #35) identified by the survey team that the facility failed to ensure these Residents maintained acceptable parameters of nutritional status. During an interview on 7/25/24 at 2:41 P.M. the Administrator said that the previous Dietitian had left in January of 2024, and that there had not been a qualified nutrition professional to cover during the interim. The Administrator said that the facility had not employed a Dietitian from 1/18/24 until 6/4/24. During a follow-up interview on 7/31/24 at 8:04 A.M., the Director of Operations (Governing Body, representative) and the Administrator (Governing Body, representative) were present. The Administrator said that he would rely on clinical staff to make him aware of a critical need for a Dietitian, and that cycling Dietitians from other buildings would have to be something directed by the governing body. The Director of Operations said she had started in April and was aware that the facility did not have a Dietitian. The Director of Operations said that if there was ever a need, and things were dire, that they could cycle a Dietitian from another building owned by the company, but that she didn't feel there was a need. During an interview on 8/21/24 at 11:50 A.M., the Director of Operations said that there was a Director of Operations in the facility on the following dates 1/25/24, 2/12/24, 2/28/24. The Director of Operations said she was in the facility on 4/20/24, 5/17/24, 5/30/24, 6/20/24, 6/26/24, and on 7/8/24. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the job description titled, Director of Operations, undated, included but not limited to the following: the Regional Director of Operations is responsible for ensuring that the assigned region ensures a high level of quality care based on established nursing standards and resident rights while supporting and assisting with the implementation of facility policy and state regulations. Also includes formulating policies, monitoring budgets, overseeing programs and assessing patient satisfaction. They set and meet financial goals and strive to satisfy all federal and state laws and mandates. 48990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on observations, interviews, policy review, and record review, the facility staff failed to ensure medical records were complete and accurately documented in accordance with professional standard of practice for three Residents (#88, #263, and #35) out of 39 total sampled residents. The facility also failed to maintain complete medical records in accordance with professional standards of practice for one of three sampled discharge records. Specifically: 1.) For Resident #88, nursing documented a peripherally inserted central catheter (PICC) dressing change as implemented, when it was not. 2.) For Resident #263, nursing documented a PICC dressing change as implemented, when it was not. 3.) For Resident #35, nursing did not complete skin checks in the electronic health record when it was signed off on Treatment Administration Record (TAR) as complete. 4.) For Resident #110 the facility failed to obtain orders for Registered Nurse (RN) pronouncement and release of body following the resident's death and failed to document in the medical record that the patient had expired. Findings include: Review of the facility policy titled Charting and Documentation, revised ,d+[DATE], indicated: 6. Documentation of procedures and treatments will include care-specific details including: a. The date and time the procedure was provided. e. Whether the resident refused the procedure/treatment. 1.) Resident #88 was admitted to the facility in [DATE] with diagnoses including diabetes and hypertension. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #88 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of Resident #88's nursing progress note, dated [DATE], indicated: - Removed PICC line per NP's (Nurse Practitioner's) order. Review of Resident #88's active physician's orders indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- PICC: Change transparent dressing 24 hours post-insertion or on admission, then every week and as needed, one time a day every Wed (wednesday) for IV (intravenous) sterile Dressing Change, initiated [DATE]. -PICC: Measure external catheter length on admission, with each dressing change, & as needed. one time a day every Wed for Catheter length, initiated [DATE]. -PICC: Change needless [sic] connector on admission, every week, & as needed, and after blood draws. one time a day every Wed for Needless [sic] connector change, initiated [DATE]. Review of Resident #88's Treatment Administration Record (TAR) indicated the follow orders were documented as implemented on [DATE]: - PICC: Change transparent dressing 24 hours post-insertion or on admission, then every week and as needed, one time a day every Wed for IV sterile Dressing Change. -PICC: Measure external catheter length on admission, with each dressing change, & as needed. one time a day every Wed for Catheter length. -PICC: Change needless [sic] connector on admission, every week, & as needed, and after blood draws. one time a day every Wed for Needless [sic] connector change. On [DATE] at 8:28 A.M., the surveyor observed Resident #88's bilateral arms which had several small healed red circular areas. Resident #88 said those healed, circular areas were from PICC lines he/she used to have. Resident #88 said the last PICC line was removed about a month ago. Resident #88 did not have any current PICC lines in place. During an interview on [DATE] at 8:48 A.M., Nurse #14 said Resident #88 did not have a PICC line. Nurse #14 said it was discontinued this month. Nurse #14 said the orders for the PICC line care should have been discontinued when the PICC was removed, but it was not. Nurse #14 said the order to change the PICC dressing, measure external catheter, and change needless connector should not have been documented as completed when it was not, because he/she did not have a PICC line at that time. During an interview on [DATE] at 8:26 A.M., the Director of Nursing (DON) said the PICC dressing change and associated PICC orders should not have been documented as implemented if they were not. The DON said these orders should have been clarified instead of documented as implemented. 2.) Resident #263 was admitted to the facility in [DATE] with diagnoses including cellulitis (an infection in the skin and underlying tissue) and osteomyelitis (an infection in the bone). Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #263 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #263 required IV (intravenous) access and IV medications. Review of Resident #263's active physician's orders indicated: - PICC: Measure external catheter length on admission, with each dressing change, & as needed. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one time a day every 7-day(s) change picc [sic] dressing weekly AND as needed, initiated [DATE]. Review of Resident #263's Treatment Administration Record (TAR) indicated the following order documented as implemented on [DATE]: -PICC: Measure external catheter length on admission, with each dressing change, & as needed, one time a day every 7 day(s) change picc [sic] dressing weekly. On [DATE] at 1:40 P.M., the surveyor observed Resident #263 in bed with IV medications infusing through a PICC. Resident #263's PICC dressing was dated [DATE]. On [DATE] at 07:16 A.M., the surveyor observed Resident #263 in bed with IV medications infusing through a PICC. Resident #263's PICC dressing was dated [DATE]. On [DATE] at 12:16 P.M., the surveyor observed Resident #263 in bed with IV medications infusing through a PICC. Resident #263 said he/she was concerned that staff didn't know how to manage his PICC line and IV medications. Resident #263 said he/she had never been offered to have the PICC dressing changed since he/she was admitted to the facility, and that the PICC dressing in place, which was dated [DATE], was from the hospital prior to his/her admission. During an interview on [DATE] at 12:26 P.M., Nurse #14 visualized Resident #263's PICC dressing, which was dated [DATE], and said this should have been changed, but it was not. Nurse #14 said that since the PICC dressing was not changed, it should not have been documented as implemented on [DATE]. During an interview on [DATE] at 8:26 A.M., the Director of Nursing (DON) said the PICC dressing change should not have been documented as implemented if it was not. 50338 3. Resident #35 was admitted to the facility in February 2024 with diagnoses including stroke affecting left side, diabetes, and post-traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated that Resident #35 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Review of physician's orders, dated [DATE], indicated weekly skin checks every evening shift every Wednesday. Do skin evaluation in electronic health record (EHR). Review of Treatment Administration Record (TAR) dated, [DATE], indicated Weekly Skin Check every evening shift every Wednesday. Do skin evaluation in electronic health record (EHR). Review of TAR dated [DATE]-[DATE], weekly skin checks signed off by Nurse #8 on [DATE], [DATE], and [DATE] and Nurse #18 on [DATE]. Review of skin check evaluations in the EHR, dated [DATE]-[DATE], failed to have documentation to support skin checks were completed as ordered. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of TAR dated [DATE]-[DATE], weekly skin checks implemented by Nurse #8 on [DATE], [DATE], and [DATE] and Nurse #14 on [DATE]. Review of skin check evaluations in EHR, dated [DATE]-[DATE], failed to have documentation to support skin checks were completed as ordered. During an interview on [DATE] at 4:39 P.M., Nurse #8 said she signed off on skin checks ,d+[DATE], , d+[DATE], and ,d+[DATE] but did not document in EHR. Nurse #8 says she signed off on skin checks , d+[DATE], ,d+[DATE], and ,d+[DATE] but she did not complete skin assessment in EHR. Nurse #8 says she does the skin checks but forgets to go back and complete documentation in the EHR. During an interview on [DATE] at 11:53 A.M., Director of Nursing (DON) said skin checks should be done weekly according to physician order and documented on TAR with resident assessment tab in EHR. 49880 4. Review of facility policy titled Discharge/ Transfer Process, dated as revised ,d+[DATE] indicated the following: -When a resident is transferred or discharged from the facility, details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving healthcare facility or provider. -5. When a resident is transferred or discharged from the facility, pertinent information regarding the transfer/ discharge will be documented in the medical record, including -a. Physician order -b. The discharge/ destination -c. Reason for discharge/transfer Resident #110 was admitted to the facility in [DATE] with diagnoses that included cerebral infarction, paraplegia, urinary retention and low back pain. Review of Resident #110's most recent Minimum Data Set (MDS) Assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating that Resident #110 had moderate cognitive impairment. The MDS further indicated that the Resident was on hospice services. The MDS completed on [DATE] indicated that he/she died in the facility. Review of Resident #110's progress notes failed to indicate that a Physician or Nurse Practitioner (NP) was notified of the Resident's death. Progress notes also failed to provide information that the Resident had died . Review of Resident #110's physician's orders failed to indicate any orders for RN pronouncement or release of body to funeral home. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:11 A.M., Nurse #2 said when a resident dies, nursing staff need to confirm the death. Nurse #2 said that a call needs to be placed to the Physician or Nurse Practitioner for notification of the death and a physician's order needs to be obtained for pronouncement and release of the body to the nursing home. Nurse #2 said that the nurse should write a note about the event and the assessment of the resident. During an interview on [DATE] at 10:54 A.M., the Director of Nurses (DON) said that when a resident dies in the facility the nurse needs to notify the physician or NP of the resident's passing and obtain an order for RN pronouncement and release of the body to the funeral home. The DON further said that a progress note should be written in the resident's medical record about the event. The DON said since the record is missing this information, the record is not complete.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48990 Based on observations, record review, and interviews the facility failed to implement the infection prevention and control program. Specifically: 1.) The facility failed to ensure precaution gowns were appropriately implemented during wound care for residents on enhanced barrier precautions. 2.) The facility failed to ensure staff performed appropriate hand hygiene after removing gloves during wound care. 3.) The facility failed to ensure nursing implemented infection control standards for blood glucose cleaning. Findings include: 1.) The facility failed to ensure precaution gowns and gloves were appropriately implemented during wound care for residents on enhanced barrier precautions. Review of the facility policy titled Enhanced Barrier Precautions, dated 4/1/2024, indicated: - EBP (Enhanced Barrier Precautions) requires wearing disposable gloves and an isolation gown prior to high contact activity. - High contact resident care activities include: wound care: any skin opening requiring a dressing. On 7/30/24 at 8:01 A.M., the surveyor observed the Wound Physician and the Unit Supervisor performing wound care on a resident with a sign at the doorway that indicated the need for Enhanced Barrier Precautions. The Wound Physician and Unit Supervisor were not wearing precaution gowns and were only wearing gloves. On 7/30/24 at 9:06 A.M., the surveyor observed the Wound Physician and the Unit Supervisor performing wound care on another resident that also had a sign at the doorway that indicated the need for Enhanced Barrier Precautions. The Wound Physician and Unit Supervisor were not wearing precaution gowns and were only wearing gloves. During an interview on 7/30/24 at 11:32 A.M., the Wound Physician said that nobody in the facility had told her that she needed to wear a precaution gown during wound care when residents were on enhanced barrier precautions. During an interview on 8/1/24 at 9:21 A.M., the Unit Supervisor said he and the Wound Physician were not wearing precaution gowns, but that they should have been since both residents were on enhanced barrier precautions for chronic pressure wounds. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said precaution gowns should have been worn, in addition to gloves, during wound care on any residents on enhanced barrier precautions. 2.) The facility failed to ensure staff performed appropriate hand hygiene after removing gloves during wound care. Review of the facility policy titled Hand Washing, revised 12/2019, indicated: 6. Use an alcohol-based hand rub, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: after removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. a. Perform hand hygiene before and after glove use. On 7/29/24 at 1:51 P.M., the surveyor observed Nurse #14 perform wound care for a stage four pressure ulcer. After removing the soiled dressing from the Resident's wound, Nurse #14 removes her gloves and does not perform hand hygiene prior to applying a new pair of gloves. Nurse #14 then takes a towel from a chair and repositions the Resident, while wearing same pair of gloves. Nurse #14 then removes those gloves and does not perform hand hygiene prior to applying another new pair of gloves and begins cleansing the wound using wound cleanser and gauze. Nurse #14 removed gloves and performs hand hygiene using alcohol based hand rub and applies a new pair of gloves. Nurse #14 then removes a soiled dressing from another pressure wound, then removes her gloves and does not perform hand hygiene prior to applying a new pair of gloves and continues to begin cleansing this wound using wound cleanser and gauze. During an interview on 7/29/24 2:14 P.M., Nurse #14 said she should have sanitized her hands every time she removed the gloves but did not. During an interview on 8/1/24 at 7:47 A.M., the DON said she had provided Nurse #14 education regarding hand hygiene during wound care previously. The Director of Nursing (DON) said hand hygiene should be performed every time gloves are removed and before new gloves applied during wound care. 44095 3.) The facility failed to ensure nursing implemented infection control standards for blood glucose cleaning. Review of the facility policy, Blood Glucose Monitoring Device Cleaning, dated as revised 10/2022, indicated that it is the facility policy to clean and disinfect blood glucose meters between each resident test to avoid cross contamination issues. - The cleaning wipes will be provided by the facility; cleaning should be completed following every time the meter is used. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PROCEDURE: 1. Wash hands with soap and water or use hand sanitizer. 2. Put on clean gloves. 3. Remove a disposable disinfectant wipe from the storage container. 4. Clean the outside of the meter with a disposable disinfectant cloth. Avoid coming in contact with the electronic components and or strip insertion area. 5. Utilizing a new disinfectant cloth, disinfect the meter following manufacturer's recommendations 6. Check with Manufacturers paperwork, meters should only be cleaned with alcohol pads in emergent situations. 7. Follow manufacturer's label regarding time disinfectant must remain in contact with meter (visibly wet) for effectiveness. 9. It is recommended but not required that Glucometers be cleaned at the beginning of each shift. a. On 7/23/24 at 8:18 A.M., the surveyor observed Nurse #8 gather supplies to obtain a Resident's blood sugar. On 7/23/24 at 8:21 A.M., the surveyor observed Nurse #8 obtain a Resident's blood sugar. Nurse #8 exited the room with the contaminated glucometer and returned it to the medication cart. On 7/23/24 at 8:22 A.M., the surveyor observed Nurse #8 obtain an alcohol pad and wipe the alcohol pad one-half centimeter around the test strip insertion area on the glucometer. Nurse #8 then placed the glucometer in a black bag. During an interview on 7/23/24 at 8:23 A.M., Nurse #8 said she always cleans the glucometer with an alcohol pad. b.) On 7/24/24 at 8:00 A.M., the surveyor observed Nurse #5 return to her medication cart. Nurse #5 said she needed to clean the glucometer. Nurse #5 began to clean the glucometer with an alcohol pad. During an interview on 7/24/24 at 8:01 A.M., Nurse #5 said she cleans the glucometers with an alcohol pad. During an interview on 7/29/24 at 4:38 P.M., the Director of Nursing said nursing should clean the glucometer with the approved cleaning wipes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 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** 50338 Based on record reviews and interviews, the facility failed to assess for eligibility, and offer pneumococcal and influenza vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations and facility policy for four Residents (#47, #24, #48 and #81) out of a total of five residents reviewed. Findings include: Review of the CDC website Pneumococcal Vaccine Timing for Adults greater than or equal to [AGE] years (cdc.gov), dated 3/1/24 indicated but was not limited to the following: - For adults 65 and over who have not had any prior pneumococcal vaccines, then the patient and provider may choose Pneumococcal conjugate vaccine (PCV) 20 or PCV15 followed by Pneumococcal polysaccharide vaccine (PPSV) 23 one year later. -For adults 65 and over who has had Pneumococcal Conjugate Vaccine 13 (PCV13) and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) and it has been 5 years or greater since the last Pneumococcal Vaccination, then the patient and the vaccine provider may choose to administer the 20-Valent Pneumococcal Conjugate Vaccine (PCV20). - All adults should have a current flu vaccine, but adults aged [AGE] years or older are recommended to receive a high dose or adjuvanted flu vaccine (for example, Fluzone High-Dose Quadrivalent inactivated flu vaccine, Flublok Quadrivalent recombinant flu vaccine, or Fludac Quadrivalent adjuvanted inactivated flu vaccine). Review of the facility policy, titled Pneumococcal Vaccination, dated 2/23, indicated it is the policy of the facility that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. -Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series with 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. -Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. -Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. - Pneumococcal vaccines will be administered to residents per our facility's physician-approved pneumococcal vaccination protocol. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-For residents who receive the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. Review of the facility policy, titled Influenza Vaccine, dated 2/2023, indicated it is the policy of the facility to minimize the risk of resident acquiring, transmitting, or experiencing complications from influenza by ensuring that each resident is informed about benefits and risks of immunizations. Residents have the opportunity to receive the vaccine unless medically contraindicated, refused, or was already immunized. Ensure documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization and the administration or the refusal of or medical contraindications to the vaccine. All residents and employees who have no medical contraindications to the vaccine should be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representative). 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. 4. Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical record. 5. For those who receive the vaccine, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. Review of the Resident Assessment Instrument (RAI), dated 10/23, indicated once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins. 1.) Resident #47 was admitted to the facility in August 2022 with diagnoses including diabetes and age was greater than 65 at time of admission. Review of Resident #47's Minimum Data Set (MDS) assessment, dated 4/23/24, indicated: O0300. Pneumococcal Vaccine A. Is the resident's Pneumococcal vaccination up to date? No. B. If pneumococcal vaccination not received, state reason. Not Offered. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record, failed to include documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization or either gave consent or refused the pneumococcal immunization. 2.) Resident #24 was admitted to the facility in August 2022 with diagnosis including Multiple Sclerosis and age was greater than 65 at time of admission. Review of Resident #24's MDS assessment, dated 6/21/24, indicated: O0250. Influenza Vaccine A. Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season? No. C. If influenza vaccine not received, state reason: Not offered. Review of the medical record, failed to include documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of the influenza immunization or either gave consent or refused the influenza immunization. 3.) Resident #48 was admitted to the facility in October 2022 with diagnosis including interstitial pulmonary disease. Review of Resident #48's MDS assessment, dated 7/12/24, indicated: O0250. Influenza Vaccine A. Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season? No. C. If influenza vaccine not received, state reason: Not offered. Review of the medical record, failed to include documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of the influenza immunization or either gave consent or refused the influenza immunization. 4.) Resident #81 was admitted to the facility June 2023 with diagnosis including chronic kidney disease. Review of Resident #81's MDS assessment, dated 5/30/24, indicated: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	O0250. Influenza Vaccine A. Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season? No. C. If influenza vaccine not received, state reason: Received outside of the facility. Review of the medical record failed to include documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of the influenza immunization or gave consent or refused the influenza immunization. Review of the medical record did not indicate influenza vaccine was given outside of the facility, specifically the immunization tab indicates influenza vaccine was last administered in 2022. During an interview on 7/31/24 at 10:50 A.M., the Infection Preventionist (IP) said the admitting nurse determines if a resident requires the pneumococcal and influenza vaccines and obtains consent at that time, from the resident/family. She said any vaccinations that are administered in the facility are documented under immunization tab in electronic health record (EHR). The IP does not keep any additional records to indicate influenza clinics or consents obtained for immunizations, all documentation would be in residents' medical records. During an interview on 7/31/24 at 11:46 A.M., the Director of Nursing said the facility did not have documentation to support that Resident #47, Resident #24, Resident #48, or Resident #81 were educated, offered, or received the pneumococcal or influenza immunizations but should have.		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 48990 Based on policy review, observation and interviews, the facility failed to ensure its staff implemented the facility smoking policy for one Resident (#44) out of a total of 39 residents sampled. Specifically, the facility failed to ensure staff stored Resident #44's smoking materials in a locked area. Findings include: Review of the facility document titled Smoking (Including Vaping) Policy and Safety Agreement, undated, indicated: - You may not retain your cigarettes, or other smoking materials such as disposable/non-rechargeable e-cigarettes, chewing tobacco, lighters, matches, or other sources of ignition. They will be stored in a locked area by the staff. During a smoking observation on 7/25/24 and 10:19 A.M., three of five residents smoking independently outside said they keep their own cigarettes and lighters in their possession because if they don't the staff will not get them for them timely. Resident #44 was admitted to the facility in May 2024 with diagnoses including asthma and heart failure. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/3/24, indicated Resident #44 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This MDS also indicated Resident #44 currently used tobacco. Review of Resident #44's plan of care related to tobacco use, revised 7/22/24, indicated: - Resident will Adhere to the Tobacco/Smoking Policies of the Facility. Review of Resident #44's Smoking (Including Vaping) Policy and Safety Agreement, dated 7/13/24, indicated Resident #44 was informed of the following policy: - You may not retain your cigarettes, or other smoking materials such as disposable/non-rechargeable e-cigarettes, chewing tobacco, lighters, matches, or other sources of ignition. They will be stored in a locked area by the staff. On 7/26/24 at 7:38 A.M., the surveyor observed Resident #44 self-propelling down the hall towards his/her room. Resident #44 said he/she was just outside smoking and smelled of smoke. Resident #44 went into his/her room without giving any smoking materials to Nurse #10, who was sitting at the nurse's station within view of the Resident's return path into his/her room which is directly across from the nurse's station. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/26/24 at 8:18 A.M., the surveyor observed Resident #44 self-propel back into the hall and hand a pack of cigarettes to Nurse #10. Resident #44 said to Nurse #10 that she got the cigarettes yesterday, but she didn't give them to a nurse. During an interview on 7/26/24 at 8:35 A.M., Nurse #10 said there are not systems in place to check if Resident's give their smoking materials to staff to lock up. Nurse #10 said she knew Resident #44 had self-propelled outside to smoke multiple times during the 11-7 shift that night, but she never asked or checked that smoking materials were returned and locked up, but that she should have. Nurse #10 said a system being in place would be helpful because many residents don't return their smoking materials. During an interview on 7/25/24 at 10:01 A.M., Certified Nurse Assistant (CNA) #4 said she works the day shift. CNA #4 said she is not aware of where any smoking materials are kept because the smokers on the floor are all independent and manage all their smoking needs themselves. CNA #4 said she didn't think smoking materials needed to be locked up. During an interview on 7/25/24 at 10:05 A.M., Nurse #14 said smoking materials should be locked up behind the nurse's station and that nurses should check with residents who smoke to ensure their smoking materials are locked up. Nurse #14 shows the surveyor a black box that is located at the nurse's station and said this is the smokers' box where resident smoking materials should be kept. This smoking box has a lock on it, that was not locked. This black box contains many empty bags with resident names on them. There is not a bag labeled with Resident #44's name. Nurse #14 said this black smokers' box should be locked at all times but was not. During an interview on 7/26/24 at 10:02 A.M., the Director of Nursing (DON) said smoking materials should not be stored in resident rooms at any time, even if they are assessed to be able to smoke independently. The DON said each time a resident would like to go outside to smoke they should alert a nurse who should retrieve all smoking materials from the locked smokers' box. The DON said the smoking materials should be returned to the nurse immediately after returning from smoking. The DON said the nurses are expected to check and collect smoking materials if any resident's do not return them. The DON said if any resident declined to allow nursing to lock up smoking materials, then she would expect to be notified because that resident would need to be given a 30-day notice of discharge to ensure the facility could keep that resident and the other residents of the facility's environment safe. The DON said since Nurse #10 was aware Resident #44 was outside smoking multiple times that Nurse #10 should have followed up and ensured the smoking materials were secured. The DON said the smokers' box should never have been left unlocked.		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48990 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff. Specifically, the facility failed to provide the required training necessary to meet the needs of each resident. Findings include: Review of the Facility Assessment, dated [DATE], indicated, but was not limited to: -3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. At orientation, attendees are educated on the following: organizational structure, mission statement, philosophy of care, the characteristics of our resident population, federal and state regulations, OBRA, quality of care, quality of life, resident rights, resident bill of rights, facility practices, behavior policy, Joint Commission, QAPI process, OSHA, chemicals hazard, the Right to Know, all emergency codes; location of policies and procedures, disaster and evacuation policy and procedure including bomb threats. -We also tour the facility and meet the individual departments and explain their function. We discuss elevator use, explain the alarm system, show the emergency, and fire equipment location, and demonstrate the telephone and paging system, the call light system, safety practices including workplace violence, sexual harassment, and ergonomics. Infection control policy and procedure, CDC standard precautions, hand hygiene; disease specific isolation, exposure control plan, bloodborne pathogens including transmission; Hepatitis B vaccine; Personal Protective Equipment (PPE); Tuberculosis Policy and Procedure; Ombudsman program; privacy and confidentiality; HIPAA; Dignity; Resident Rights; Verbal and Physical Abuse, Neglect, Mistreatment, Psychological Harm and Misappropriation of property. Incident reporting policy and procedure, Resident incident reports, Safety and Accident Precautions, resident Safety, Employee Safety, Communication, Annual in-service Education requirements, Dementia Training, and Annual Performance Evaluation. The benefits, employee responsibilities regarding Time Schedule/request time off and time clock, paycheck distribution, parking, breakroom area, Personal Handbook and Job Description. -Competencies by department: All departments have annual competencies completed by the (Staff Development Coordinator) SDC and their respective Department Manager. Any employee who through their actions or by management oversight is determined to require additional training will be provided the education and new competencies completed. -All departments receive an initial 8 hours of dementia training and 4 hours annually. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Competencies by department: Licensed Nurse Annually: Medication Administration, Narcotic Count, Insulin Administration, Glucometer, Blood glucose monitoring, IM, ID, SC administration, IV administration (certified, then annual education), Treatment administration, Oxygen High Flow Administration, Pacemaker check, Enema/suppository, G-tube, Catheterization, Colostomy care, Suctioning, Specimen collection, Pulse Oximeter (annually), Vital Signs/Assessment, Nebulizer, Linen Management, Respiratory etiquette, Documentation, AED/Emergency CPR (certificate every 2 years), Pleurex catheter, Mini Doppler, Psychotropic medication, Emergency Medication Supply, SBAR. -Competencies by department: Licensed Nurses on hire and PRN (as needed): Medicare/Acute care charting, Transcribing order, Editing procedure, Ordering medication, Nursing summaries, DNR Order, Laboratory protocol, Infection Control Program, Skin Prevention/Wound Program, CPAP/BIPAP, Fall Prevention Program, Nutritional Program, Pain Management program, Accident/Incident Investigation Reports, Side rails/restraint policy and procedure, C.N.A. Assignment/report/flowsheets, Elopement (Code 10) Procedure, Bowel Protocol, Weights, I&O, Meals, Change in Condition, Nursing Assessments, Medication Reconciliation, Consents, DNR, Advance Directives, Psychotropic medication, Flu and pneumonia, Admission Observations, Discharge/Transfers, MDS Process, Equipment, Death Notice, RN pronouncement, Rehabilitation PT/OT/SLP, Role of Dietary, Role of Social Services, Role of Activities, IV Therapy - programming pump, peripheral, central lines, Hanging solutions, Body mechanics, Hoyer and Sit to Stand lifts, ,d+[DATE] person transfer, Person-Centered Care Plan, Baseline care plan, Comprehensive care plan. -Competencies by department: C.N.A. Annually: Infection Control, Vital Signs, Bathing/Dressing/Grooming, Elimination, Nutrition, Transfer/Positioning/Restraints, Documentation The surveyor requested staff education files with all training and competencies for 5 Certified Nurse Assistants (CNA) and 12 Licensed Nurses on [DATE] at 9:07 A.M., [DATE] at 12:20 P.M., [DATE] at 8:07 A.M., [DATE] at 12:32 P.M., and [DATE] at 7:47 A.M. Record review of the 17 personnel files failed to indicate any training was done upon hire during orientation for the following areas, which were required to be completed during orientation as indicated in the Facility Assessment: codes; location of policies and procedures, disaster and evacuation policy and procedure including bomb threats, tour of facility, elevator use, explain the alarm system, show the emergency, and fire equipment location, and demonstrate the telephone and paging system, the call light system, and ergonomics, CDC standard precautions, hand hygiene; disease specific isolation, exposure control plan, Tuberculosis Policy and Procedure, Ombudsman program, Dignity, Incident reporting policy and procedure, Resident incident reports, Safety and Accident Precautions, Resident Safety, Employee Safety, Communication, Annual in-service Education requirements, Dementia Training, and Annual Performance Evaluation. During an interview on [DATE] at 7:40 A.M., The Staff Development Nurse said nursing competencies haven't been done in years. The Staff Development Nurse said the orientation process was missing a lot of necessary training outlined in the Facility Assessment. The Staff Development Nurse said they couldn't locate any other documentation that orientation, training, or competencies had been completed. The Staff Development Nurse showed the surveyor an annual competency packet, which she said was done in March for all staff. The Staff Development Nurse said this annual competency packet did not address all training and competency requirements noted in the facility assessment. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Annual Competency packet, dated [DATE]-[DATE], indicated the following topics were completed included: Infection Control, Blood born pathogens, Consents/declination, handwashing station/competency/DON/DOFF competency, Elopement, Smoking Plan, Customer Service, Cell Phones, QAPI, Code of Conduct, Safety/OSHA, Activities, Food/Dietary. Review of the Annual Competency packet, dated [DATE]-[DATE], failed to indicate other training and competencies listed in the facility assessment specific for CNAs and licensed nurses were completed. This Annual Competency packet includes training that was indicated in the Facility Assessment that should have been completed upon hire, but was not. Review of 12 Licensed Nurses education files indicated the following training/competencies completed as applicable on hire, annually, or as needed: - 0 out of 12 had documentation they had completed required all training upon hire as required by the Facility Assessment. - 0 out of 12 had documentation they had completed competencies upon hire or annually as required by the Facility Assessment. - 2 out of 12 had documentation they had completed dementia training as required by the Facility Assessment. Review of 5 Certified Nurse Assistant (CNA) education files indicated the following training/competencies completed as applicable on hire, annually, or as needed: - 0 out of 5 had documentation they had completed required all training upon hire as required by the Facility Assessment. - 0 out of 5 had documentation they had completed competencies upon hire or annually as required by the Facility Assessment. - 0 out of 5 had documentation they had completed dementia training as required by the Facility Assessment. - 0 out of 5 had documentation they had completed required 12 hours of required in-service hours. During an interview on [DATE] 1:51 P.M., Nurse #14 said she never had any nursing competencies completed at the facility since she was hired on [DATE]. During an interview on [DATE] at 3:58 P.M., Nurse #17 said she never had any nursing competencies completed at the facility since she was hired on [DATE]. During an interview on [DATE] at 7:39 A.M., Nurse #2 said she never had any nursing competencies completed at the facility since she was hired on [DATE]. During an interview on [DATE] at 11:31 A.M., CNA #8 said she had never had CNA specific competencies completed since she was hired on [DATE]. (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 11:10 A.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said training and competencies should have been completed based on the facility assessment for all staff on hire, annually and as needed. The DON and ADON clarified that the annual competencies should also be done upon hire, such as medication administration, IV administration, and documentation. The DON and ADON said all training and competencies should be documented and readily available. The DON and ADON said all nursing competencies had not been being completed because they had trouble filling the staff development nurse role and they were planning an in-service for nursing competencies but hadn't found time to do it. The DON and ADON referred to the annual competency packet, which she said was done in March for all staff, and said it did not address all training and competency requirements noted in the facility assessment. During an interview on [DATE] at 7:47 A.M., the Director of Nursing (DON) said she would expect training and competencies to be completed as indicated in the Facility Assessment or by regulation. The Administrator said he would expect training for effective communications, resident rights, QAPI, infection control, 12 hours of in-service hours for CNA's, and behavioral health needs, but it was not consistently implemented. During an interview on [DATE] at 10:56 A.M., the Administrator said he would expect training and competencies to be completed as indicated in the Facility Assessment or by regulation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48990 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to implement mandatory effective communication training for 17 direct care staff. Findings include: Review of the Facility Assessment, dated 5/24/24, indicated: 3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. -The itemized list of education provided at orientation included: Communication. The surveyor requested staff education files with all training and competencies for 17 direct care staff (5 Certified Nurse Assistants (CNAs) and 12 Licensed Nurses) on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 17 employee education files indicated the following training/competencies completed as applicable on hire, annually, or as needed: - 0 out of 17 had documentation they had completed any effective communications training. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse could not locate any documentation that effective communication training had been completed for the 17 direct care staff reviewed by the surveyor. During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said effective communications training should be completed at the facility as indicated in the Facility Assessment and documentation of completion should be readily accessible. The DON said she was not aware of any effective communication training being completed in the facility. During an interview on 8/1/24 at 10:56 A.M., the Administrator said he was unaware effective communications was a required training, but that it should be completed at the facility since it is included in the Facility Assessment. The Administrator said he was not aware of any effective communication training being completed in the facility.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 48990 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to ensure that staff members were educated on the rights of the resident on hire for 14 out of 17 direct care staff education files reviewed. Findings include: Review of the Facility Assessment indicated the following: 3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. -The itemized list of education provided at orientation included: Resident Rights. The surveyor requested staff education files with all training and competencies for 17 direct care staff (5 Certified Nurse Assistants (CNAs) and 12 Licensed Nurses) on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 17 employee education files indicated the following training/competencies completed as applicable on hire, annually, or as needed: - 3 out of 17 had documentation they had completed resident rights training upon hire. During an interview on 8/1/24 at 11:31 A.M., CNA #8 said she had never received resident rights training in the facility since she was hired on 6/27/22. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse could not locate any documentation that resident rights had been completed upon hire for 14 out of the 17 direct care staff reviewed by the surveyor. During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said resident rights training should be completed upon hire as indicated on the Facility Assessment and documentation of completion should be readily accessible. During an interview on 8/1/24 at 10:56 A.M., the Administrator said resident rights training should be completed upon hire as indicated on the Facility Assessment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48990 Based on review of the Facility Assessment, employee education record review, policy review and interviews, the facility failed to implement mandatory training on Quality Assurance and Performance Improvement (QAPI) for 17 employees. Findings include: Review of the Facility Assessment, dated 5/24/24, indicated: 3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. -The itemized list of education provided at orientation included: QAPI Process. Review of the facility policy titled QAPI Plan, dated reviewed 2/7/21, indicated: - Mandatory training that outlines and informs staff of the elements and goals of the facility's Performance Improvement program shall be provided at the time of hire and as needed. The surveyor requested staff education files with all training and competencies for 17 direct care staff (5 Certified Nurse Assistants (CNAs) and 12 Licensed Nurses) on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 17 employee education files indicated the following training/competencies completed as applicable on hire, annually, or as needed: - 0 out of 17 had documentation they had completed QAPI training upon hire. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse could not locate any documentation that QAPI training had been completed on hire for 17 direct care staff reviewed by the surveyor. During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said QAPI training should be completed on hire and as needed as indicated in the Facility Assessment and documentation of completion should be readily accessible. During an interview on 8/1/24 at 10:56 A.M., the Administrator said QAPI training should be completed on hire and as needed as indicated in the Facility Assessment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 48990 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to implement mandatory infection control training upon hire for 15 out of 17 direct care staff. Findings include: Review of the Facility Assessment, dated 5/24/24, indicated: 3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. -The itemized list of education provided at orientation included: Infection control policy and procedure. -Competencies by department: Licensed Nurse: On hire and PRN (as needed): Infection Control Program. The surveyor requested staff education files with all training and competencies for 17 direct care staff (5 Certified Nurse Assistants (CNAs) and 12 Licensed Nurses) on 07/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 17 direct care staff education files (5 Certified Nurse Assistants (CNAs) and 12 Licensed Nurses indicated the following training/competencies completed as applicable on hire. - 2 out of 17 had documentation they had completed any infection control training or competencies completed upon hire. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse could not locate any documentation that infection control training had been completed on hire for the 15 of the 17 direct care staff reviewed by the surveyor. During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said infection control training should be completed on hire as indicated in the Facility Assessment and documentation of completion should be readily accessible.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48990 Based on record review and interview, the facility failed to ensure at least 12 hours of required in-service training hours, that included dementia management training, were provided for 5 of 5 Certified Nurse Aides (CNAs) education files reviewed. Findings include: Review of the Facility Assessment, dated 5/24/24, indicated: 3.4 Every new hire must meet the minimum education and training requirements to hold and maintain their professional licensures and certifications. All new hires go through general orientation. -The itemized list of education provided at orientation included: Annual In-service Education requirements, Dementia Training. - All departments receive an initial 8 hours of dementia training and 4 hours annually. The surveyor requested staff education files with all training and competencies for 5 Certified Nurse Aides (CNAs) on 07/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 5 Certified Nurse Aides (CNAs) employee education files indicated: - 0 out of 5 had documentation they had completed any in-service training hours in the past 12 months. - 0 out of 5 had completed dementia training in the past 12 months. During an interview on 8/1/24 at 7:40 A.M., the Staff Development Nurse said she had taken the position a week ago and that the position had a lot of turnover in the last year. The Staff Development Nurse said all nurse aides need complete at least 12 hours of required in-service training. The Staff Development Nurse said they couldn't locate any documentation that the required in-service hours had been completed for the 5 Certified Nurse Aides that the surveyor had reviewed. During an interview on 8/1/24 at 1:01 P.M., Nurse #19 said she used to be the Staff Development Nurse a few months ago. Nurse #19 said in-service training hours were not being scheduled or provided for any Certified Nurse Aides (CNAs). During an interview on 8/1/24 at 7:47 A.M., the Director of Nursing (DON) said 12 hours of required in-service hours for Certified Nurse Aides (CNAs) should be provided and documentation of completion should be readily available. During an interview on 8/1/24 at 10:56 A.M., the Administrator said 12 hours of required in-service hours for Certified Nurse Aides (CNAs) should be provided.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48990 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to provide behavioral health training consistent with the requirements at S483.40 to 17 out of 17 direct care employees reviewed. Findings include: Review of the Facility Assessment Tool, dated 5/24/24, included but was not limited to the following: - Commonly admitted diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management: Psychiatric/Mood Disorders: Psychosis, Mental Disorder, Depression, Bipolar Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Intervention. - Resources Necessary for Psychiatric/Mood Disorders: Behavior Rounds, Behavior Monitoring in those residents exhibiting behaviors, Multidisciplinary care planning for individualized behavior management for residents exhibiting behaviors - Services and Care we offer based on our Resident's needs: Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual, or developmental disabilities. - Staff training/education and competencies listed failed to indicate any formalized behavioral health training course. Review of Diagnosis Report, dated 8/1/24, indicated the facility had 25 residents with substance use disorders who were residing throughout all units in the facility. Review of the Resident Matrix Report, dated 7/23/24, indicated the facility had 14 residents with post-traumatic stress disorder (PTSD) who were residing throughout all units in the facility. During a telephone interview on 7/23/24 at 10:36 A.M., the Ombudsman said there are ongoing concerns with resident's not receiving mental health services for addiction. The surveyor requested staff education files with all training and competencies for 17 direct care staff (5 Certified Nurse Assistants (CNAs) and 12 Licensed Nurses) on 7/30/24 at 9:07 A.M., 7/30/24 at 12:20 P.M., 7/31/24 at 8:07 A.M., 7/31/24 at 12:32 P.M., and 8/1/24 at 7:47 A.M. Review of 17 employee education files indicated: (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Salem Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Loring Hills Avenue Salem, MA 01970	
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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 0 out of 17 employees had documentation they had completed any behavioral health training or competencies. During an interview on 8/1/24 at 7:40 A.M., The Staff Development Nurse said there is not a formalized behavioral health training course provided to any employees. During an interview on 7/31/24 at 11:10 A.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said the facility has a large population of residents with behavioral health concerns, including substance use disorder and post-traumatic stress disorder (PTSD) who reside on all units in the facility. The DON and ADON were not aware formalized behavioral health training was required under the code of federal regulations. The DON and ADON said there was not a formalized behavioral health training course provided to any employees, but there probably should be. During an interview on 8/1/24 at 10:56 A.M., the Administrator said the facility has many residents with behavioral needs, such as post-traumatic stress disorder (PTSD) or substance use disorder. The Administrator was not aware formalized behavioral health training was required under the code of federal regulations. The Administrator said there was not a formalized behavioral health training course provided to any employees, but there probably should be.		