STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225644	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Rehab Center	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** Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to follow proper thawing practices when defrosting clams, to ensure that food was dated in the main kitchen and in one of two unit kitchenette refrigerators. Findings include: Review of the facility's policy titled Food from Outside - Safety, revised January 2023, indicated, but was not limited to, the following:It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to resident by family and other visitors. Facility staff will be appointed to check resident refrigerators for proper temperatures, food containment and quality, and disposal of items per facility policy.Foods requiring refrigeration will be received by the facility designee (activity department, food and nutrition department, charge nurse, etc.) for proper and immediate storage including labeling and dating. Review of the undated facility policy titled Thawing Foods, indicated, but was not limited to, the following:Thawing foods under cool running potable water (This process is not recommended and should only be used in an emergency and if you cook food immediately).a. Clean and sanitize the sink that food should be thawed in.b. Food items should be completely submerged under running water at a temperature of 70 degrees Fahrenheit or lower.c. Cold water must be running continuously throughout the thawing process, (avoid splashing on other food items and food contact surfaces) and they should never be thawed in the 3-compartment or hand sink. Review of the facility's policy titled Labeling and dating foods (Date Marking) dated 2020, indicated, but was not limited to, the following:Expiration dates on commercially prepared, dry storage food items will be followed. Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility and placed in/on the proper storage location utilizing the first in - first out method rotation.Once opened, all ready to eat, potentially hazardous food will be re-dated with use by date according to current safe food storage guidelines or by the manufacturers expiration date. Prepared food or opened food items should be discarded when:o The food item does not have a specific manufacturer expiration date and has been refrigerated for 7 days.o The food item is leftover for more than 72 hours. o The food item is older than the expiration date. On 9/3/25 at 7:02 A.M. the surveyor made the following observations during the initial walkthrough of the main kitchen:An opened bag of shredded cabbage with significant signs of decomposition including color and textural changes with a best if used by date of 8/27/25. A pan containing hot dogs in the walk-in refrigerator, there were globules consistent with the appearance of fat coating the hot dogs indicating the hot dogs had already been heated; the pan was labeled with two dates, 8/2 and 8/5.There was an undated package of sliced deli turkey, the package was opened and wrapped in plastic in the walk-in refrigerator.There was a container of thickened juice with a best if used by date of March 19, 2025, in the dry-storage area. On 9/3/25 at 7:17 A.M. the surveyor made the following observations in the [NAME] unit kitchenette refrigerator:A brown paper bag labeled with a Resident name and room number containing two bags of cookies and food wrapped in aluminum foil. There was no date on the inside or outside of the brown paper bag, either bags of cookies or tinfoil.A container of food labeled with a Resident name and dated 8/30.An undated (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and unlabeled container of food consistent in appearance with a creamy soup. On 9/4/25 at 11:00 A.M. the surveyor observed four bags of clams in a pan submerged in water at the bottom of a two-bay sink; there was no running water. On 9/4/25 at 11:25 A.M. the surveyor observed that the clams were still submerged in water, that the water was luke warm to the touch, that there was no water running, that the clams were completely defrosted and luke warm to the touch. During a continuous observation beginning on 9/4/25 at 11:25 A.M. the surveyor observed that the clams remained submerged in luke warm water without water running until 11:55 A.M. when the surveyor called over the Food Service Director (FSD). During interviews on 9/3/25 at 9:31 A.M. and 9/4/25 at 11:55 A.M. the FSD said that all food should be labeled and dated, and that the kitchen staff conduct daily rounds during which they would discard anything unlabeled, undated, or beyond the printed date. The FSD said that kitchen staff conduct daily rounds on the kitchenettes and would discard any food that was unlabeled or that was over three days old. The FSD said that when defrosting food the food should be placed under continuously running cold water for a few minutes, and that someone must have shut the water off in regard to the clams. The FSD said that the clams feel warm to touch and should be discarded as they are no longer safe to eat. During an interview on 9/3/25 at 7:22 Nurse #2 said food in the kitchenette refrigerator must be labeled, dated, and discarded after 72 hours or if undated. Nurse #2 inspected the inside and outside of the brown paper bag, and said the bag was not labeled but should have been. Nurse #2 said the brown paper bag containing food was brought in yesterday and that she would label the bag.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure that one Resident (#15) was not left with pills to self-administer without first determining if it was safe, out of a total sample of 19 residents. Specifically, staff left pills at Resident #15's bedside for self-administration without completing a self-administration of medication assessment.Findings include:Review of the facility policy titled Self-Administration of Medications, revised January 2023, indicated:-The resident may request to keep medication at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions.-The staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident upon request. -In addition to a general evaluation of decision-making capacity, the nurse will perform a more specific skill assessment, this can be accomplished on paper or through the EHR (electronic health record) system.-If this assessment determines that the resident cannot safely administer medications, all medications should be administered by the nurse and stored medication in the med cart. [sic].Resident #15 was admitted to the facility in June 2020 with diagnoses including hypertension and diabetes.Review of the most recent Minimum Data Set (MDS) assessment, dated 7/31/25, indicated Resident #15 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. On 9/3/25 at 7:59 A.M., the surveyor observed Resident #15 in bed with two round brown pills in a medication cup on his/her bedside table. Resident #15 said please hand those to me, the nurse left them last night because I asked to take them later.On 9/3/25 at 8:02 A.M., Unit Manager #1 came into the Resident's room at the surveyor's request. Resident #15 asked Unit Manager #1 if he/she could take the two round brown pills now, because he/she forgot to take them last night. Unit Manager #1 told Resident #15 that he/she could not take these pills because they should have been taken last night and then removed them from the room. Unit Manager #1 further said pills should never have been left at bedside if the Resident was not ready to take them.During a follow-up interview on 9/4/25 at 9:20 A.M., Unit Manager #1 said a self-administration of medication assessment should be completed in the electronic medical record before any medications are left for self-administration. Unit Manager said Resident #15 never had a self-administration of medication assessment completed.Review of Resident #15's medical record failed to indicate a self-administration of medication assessment was completed since his/her admission. During an interview on 9/4/25 at 1:06 P.M., the Director of Nursing (DON) said the two round brown pills should not have been left unattended with Resident #15. The DON further said if pills are left unattended then a self-administration of medication assessment should have been completed but was not.

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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. Based on observations, interviews, and record review, the facility failed to ensure the comprehensive care plan was revised by the interdisciplinary team for one Resident (#71) out of a total sample of 19 residents. Specifically, for Resident #71, the facility failed to revise the comprehensive care plan relating to the need for a geri chair (a sturdy, padded chair on wheels that can recline which is designed to be more supportive and comfortable than a standard wheelchair, especially for people who have limited mobility and spend a lot of time sitting) for comfort and skin integrity concerns upon the care plan review following the completion of the last quarterly assessment.Findings include:Review of the facility policy titled Care Plans, revised January 2023, indicated:-PROCEDURE: 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.Resident #71 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 4/17/25, indicated Resident #71 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of plan of care related to potential for alteration in skin integrity, revised 4/26/25, indicated:-Geri chair while up to assist with comfort and positioning. -Encourage resident to limit time up in geri chair to promote healthy skin integrity and promote wound healing. On 9/3/25 at 7:50 A.M., the surveyor observed Resident #71 in bed. Resident #71 said he/she spends all day in his/her wheelchair, and it hurts his/her backside. Resident #71 said the standard wheelchair that was at the foot of his/her bed was the wheelchair he/she used.On 9/3/25 at 10:45 A.M., the surveyor observed Resident #71 sitting in a standard wheelchair. Resident #71 said his/her backside hurts so bad and this wheelchair is so uncomfortable. Resident #71 further said he/she used to have a reclining, padded wheelchair a long time ago and that it was very comfortable. Resident #71 said he/she would love to have one like that again.On 9/4/25 at 8:25 A.M., the surveyor observed Resident #71 sitting in a standard wheelchair.On 9/5/25 at 8:17 A.M., the surveyor observed Resident #71 sitting in a standard wheelchair. Resident #71 said his/her backside hurt so bad all day yesterday from this standard wheelchair. Resident #71 said he/she just got into this wheelchair this morning, so he/she is comfortable now, but after a while he/she knows it will hurt again.During an interview on 9/5/25 at 9:29 A.M., Certified Nurse Assistant (CNA) #2 said Resident #71 used to have a reclining geri chair but was not sure why he/she does not anymore. CNA #2 said she was unaware Resident #71's current standard wheelchair was uncomfortable and that he/she has no open wounds on his/her backside.During an interview on 9/5/25 at 10:01 A.M., Unit Manager #1 and Nurse #1 said all interventions on Resident #71's comprehensive care plan should be implemented or the care plan should be revised if the intervention is no longer appropriate. Unit Manager #1 and Nurse #1 said they were unaware that Resident #71's care plan indicated an intervention for geri chair while up to assist with comfort and positioning or to encourage resident to limit time up in geri chair to promote healthy skin integrity and promote wound healing. Unit Manager #1 and Nurse #1 said Resident #71 no longer has any wounds and has had a standard wheelchair since they had known him/her. Unit Manager #1 and Nurse #1 said at a minimum the care plan should have been updated during the last care plan meeting. Unit Manager #1 and Nurse #1 said they were unaware of Resident #71's current standard wheelchair being uncomfortable. Unit Manager #1 and Nurse #1 said the Director of Rehab (DOR) would have more information about Resident #71's wheelchair because the rehab department is responsible for determining which wheelchair Resident #71 should have.During an interview on 9/5/25 at 10:20 A.M., the Director of Rehab (DOR) said Resident #71 used to have a geri chair but was advanced to a standard wheelchair after his/her pressure wound healed at the beginning of the year (2025). The DOR was unsure of the exact date the standard wheelchair was implemented at the time (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the interview but stated he would get the therapy note indicating the date. The DOR said he was unaware nursing had not updated the care plan to reflect that Resident #71 had a standard wheelchair, but they should have since he/she has not had it since shortly after his/her sacral pressure ulcer healed.Review of Resident #71's consultant wound physician progress note, dated 2/5/25, indicated his/her stage four sacral pressure ulcer was healed.Review of Resident #71's therapy progress note, dated 2/24/25, signed by the DOR, indicated:-Pt (patient) to trial a wc (wheelchair) next therapy session.Review of Resident #71's medical record indicated the last quarterly Minimum Data Set (MDS) assessment was dated 4/17/25.Review of Resident #71's social services progress note, dated 4/30/25, indicated a care plan meeting was held and that the care plans were reviewed and interventions remained appropriate.During an interview on 9/5/25 at 11:53 A.M., the Director of Nursing (DON) said care plans should be reviewed and revised to ensure interventions are current and appropriate after every quarterly assessment. The DON said Resident #71's care plan should have been revised because he/she has not required the geri chair in quite some time but was not.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, interviews, and record review, the facility failed to ensure that staff accommodated food preferences for one Resident (#66), out of a total sample of 19 residents. Specifically, the facility failed to honor Resident #66's preferences and served the Resident fortified cream of wheat, which he/she disliked, instead of fortified super oatmeal as he/she requested.Findings include:Review of the facility policy titled Meal Rounds/Visits, revised January 2023, indicated:-POLICY: To determine resident's likes/dislikes and overall acceptance of meal service.Resident #66 was admitted to the facility in August 2021 with diagnoses including moderate protein calorie malnutrition.Review of the most recent Minimum Data Set (MDS) assessment, dated 6/5/25, indicated Resident #66 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 8 out of 15. Review of Resident #66's dietary progress note, dated 9/2/25, indicated:-Honor food preferences. On 9/3/25 at 8:34 A.M., the surveyor observed Resident #66 with a bowl of fortified cream of wheat on his/her breakfast tray. Resident #66 said he/she ordered a new oatmeal because the facility always sends cream of wheat, and he/she hates it. There was a meal slip on his/her meal tray that indicated 2 super oatmeal only, dislikes cream of wheat.On 9/4/25 at 8:17 A.M., the surveyor observed staff deliver Resident #66's meal tray without any discussion regarding cream of wheat or oatmeal. The surveyor observed Resident #66 in bed with two bowls of fortified cream of wheat on his/her breakfast tray untouched. Resident #66 said he/she will not eat them because he/she hates the cream of wheat. Resident #66 said he/she won't ask for the oatmeal again because he/she has told them so many times before and staff don't care. Resident #66 further said he/she is sick of having to ask for the oatmeal and then wait for it to come, if it even does come. During an interview on 9/5/25 at 9:39 A.M., Certified Nurse Assistant (CNA) #1 said she was unaware Resident #66 disliked cream of wheat. CNA #1 said any disliked food items should always be removed from the meal tray because the Resident's food preferences should always be honored.During an interview on 9/5/25 at 9:51 A.M., Unit Manager #1 said the Resident's food preferences should always be honored. Unit Manager #1 said any disliked food items should be removed from the tray unless Resident #66 said he/she wanted the food item.During a follow-up interview on 9/5/25 at 10:24 A.M., Unit Manager #1 said Resident #66 needed to have the type of hot cereal that was on his/her tray because it was fortified super cereal. Unit Manager #1 said she always gives the Resident the type of fortified super cereal that was on Resident #66's tray because it's the only type they have in the facility. Unit Manager #1 was unaware if there was more than one type of super cereal in the facility.During an interview on 9/5/25 at 10:25 A.M., the Food Service Director (FSD) said the facility has two types of super cereals, one is a fortified cream of wheat, and the other is fortified oatmeal called super oatmeal. The FSD said super oatmeal was available on all dates of the survey. The FSD said Resident #66 should have received super oatmeal and not the fortified cream of wheat because the Resident's food preferences should always be honored.During an interview on 9/5/25 at 11:53 A.M., the Director of Nursing (DON) said the Resident's food preferences should always be honored. The DON said if the facility had two types of super cereal than Resident #66 should have received the super oatmeal instead of the fortified cream of wheat.