STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265885	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Care Center	1203 N Jackson Salem, MO 65560

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, facility staff failed to ensure the amount of liquid Lorazepam medication (a controlled substance) for one resident (Resident #1) out of three sampled residents was counted at each shift change, to identify any discrepancies or prevent potential misappropriation of the medication. Staff failed to complete controlled medication counts with two staff members at each shift change for two out of two sampled medication carts as directed by facility policy. The facility census was 49.The administrator was notified on 06/16/26 of past Non-Compliance which occurred on 06/15/26 when the Director of Nursing (DON) completed in-services to licensed staff and Certified Medication Technicians (CMTs) on the facility's policies on Abuse & Neglect to include misappropriation, count controlled medications at the beginning and end of each shift with two staff members and document on the Controlled Drugs form, procedures for medication destruction, and notification of any discrepancies found with controlled medications. The DON provided re-education and implemented additional staff training to one recently hired licensed staff. 1. Review of the facility's Controlled Substance Management Policy, dated 11/01/13, showed staff are directed: -When a controlled medication is administered, the details of the administration should be documented on the accountability (controlled medication utilization) record;a) Date/time of administrationb) Amount of medication administeredc) Amount of medication remaining in the containerd) Signature of nurse administering the dose-Conduct an inventory of all controlled medications at each shift change or when keys are surrendered to another licensed staff;-Document the results of the inventory on the controlled substances shift change count sheet;-Each month the shift change count sheet will be forwarded to the DON; -Report any discrepancy in controlled substance medication inventory to the DON immediately. 2. Review of facility's investigation, dated 06/15/26, showed licensed staff did not consistently document Resident #1's amount of Lorazepam medication available on the narcotic count sheet at each shift change, the packaging for the medication was moist to touch, approximately 4.75 milliliters (ml) of the medication was unaccounted for, and staff conducted a drug-screen on all licensed staff. All nurses and CMTs were in-serviced on the facility's policies regarding controlled medications and misappropriation. Facility staff did not identify misappropriation of any controlled medications. 3. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/16/26, showed staff assessed the resident with severe cognitive impairment, and received antianxiety medication. Review of the resident's-controlled medication utilization record, dated 05/01/26 through 06/11/26, showed the record did not contain documentation staff documented the details of each administration of the resident's Lorazepam medication. Review of the resident's Physician Order Summary (POS), dated 05/01/26, showed an order for Lorazepam Oral Concentrate two milligrams (mg) / milliliters (ml), give 0.25 ml by mouth three times a day for anxiety. Review of the resident's electronic Medication Administration Record (EMAR), dated 05/12/26, did not contain documentation staff administered the resident's 6:00 P.M. dose of Lorazepam and did not contain documentation the resident refused the medication. Review of the resident's-controlled medication utilization record, dated 05/12/26, did not contain documentation staff administered the resident's Lorazepam at 6:00 P.M. During an interview (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 06/16/26 at 12:46 P.M., Registered Nurse (RN) A said only nurses have access to liquid controlled medications stored inside the med room, and the nurses are directed to document the details of each administration of a controlled medication on the corresponding controlled medication utilization record and sign the MAR after the medication is administered to the resident. RN A said staff are directed to have two nurses verify the count for each controlled medication in the medication room at the beginning and end of each shift. He/She said the DON is responsible for auditing the controlled medication logs, and if staff does not verify each controlled medication count every shift, it would make it difficult to know who is responsible if an error or discrepancy is identified. During an interview on 06/17/26 at 10:16 A.M., Licensed Practical Nurse (LPN) B said the nurses are directed to sign the MAR after each medication is administered, document the details of each controlled medication administration on the corresponding controlled medication utilization record, and verify the verify the count for each controlled medication in the med room at the beginning and end of each shift. LPN B said he/she was not sure if anyone audits the controlled medication logs, but if staff does not verify each controlled medication count every shift, it will make it difficult to identify who is responsible for a missing medication or discrepancy in the count. During an interview on 06/16/26 at 1:11 P.M., the administrator said his/her expectation is for two staff to count controlled medications and sign the forms at each shift change or change of keys. He/She said staff not counting the medications each shift creates a failed custody chain and would make it difficult to determine who is responsible for missing medications or discrepancies with the count. During an interview on 06/16/26 at 1:58 P.M., the DON said he/she expects staff to sign the MAR after each medication administration and document the details of each controlled medication administration on the controlled medication count sheet to ensure all the medications are accounted for. 4. Review of the facility's Controlled Drugs shift change form, dated 05/01/26 through 05/31/26, showed the 100/200 hall medication cart controlled drug sheet form did not contain documentation for two staff conducted an inventory at each shift change or when the keys were surrendered to another staff: -On 05/01/26, one staff signature for 7:00 A.M. and 7:00 P.M.;-On 05/02/26, one staff signature for 7:00 A.M. and 7:00 P.M.;-On 05/03/26, one staff signature for 7:00 A.M. and 7:00 P.M.; -On 05/04/26, one staff signature for 7:00 A.M.; -On 05/08/26, one staff signature for 7:00 P.M.,-On 05/09/26, one staff signature for 7:00 A.M. and 7:00 P.M.,-On 05/10/26, one staff signature for 7:00 A.M. and 7:00 P.M.,-On 05/15/26, one staff signature for 7:00 P.M.,-On 05/16/26, one staff signature for 7:00 A.M. and 7:00 P.M.,-On 05/17/26, one staff signature for 7:00 A.M. and 7:00 P.M.,-On 05/18/26, one staff signature for 7:00 A.M.;-On 05/23/26, one staff signature for 7:00 P.M. Review of the facility's Controlled Drugs shift change form, dated 05/01/26 through 05/31/26, showed the 300 hall medication cart controlled drug sheet form did not contain documentation two staff conducted an inventory at each shift change or when the keys were surrendered to another staff: -On 05/01/26, one staff signature for 7:00 A.M. and 7:00 P.M.;-On 05/02/26, one staff signature for 7:00 A.M. and 7:00 P.M.;-On 05/03/26, one staff signature for 7:00 A.M. and 7:00 P.M.; -On 05/04/26, one staff signature for 7:00 A.M.; -On 05/08/26, one staff signature for 7:00 P.M.,-On 05/09/26, one staff signature for 7:00 A.M. and no staff signature for 7:00 P.M.,-On 05/10/26, one staff signature for 7:00 A.M. and 7:00 P.M.,-On 05/11/26, one staff signature for 7:00 P.M.,-On 05/12/26, one staff signature for 7:00 A.M.,-On 05/23/26, one staff signature for 7:00 P.M. During an interview on 06/16/26 at 10:38 A.M., CMT D said staff are directed to count all controlled medications with two staff at the start and end of each shift and sign the Controlled Drugs shift change form. During an interview on 06/16/26 at 1:11 P.M., the administrator said his/her expectation is for two staff to count controlled medications and sign the forms at each shift change or change of keys. He/She said the Pharmacist does an audit at least once per month and he/she expects the DON to audit periodically but no specific frequency. During an interview on 06/16/26 at 1:58 P.M., the DON said staff are directed to count controlled medications with two staff at the beginning and end of each shift and sign the Controlled Drugs shift change form. The DON said he/she is responsible for periodically audit the controlled medication logs but was busy with other audits and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had not checked the logs in a while. During an interview on 06/17/26 at 11:02 A.M., LPN C said the oncoming and off-going nurse or CMT are expected to count each controlled medication and sign the shift change form. LPN C said if staff do not count and sign the forms each shift and there is a discrepancy with the counts, it could make it difficult to determine when the discrepancy started or who is responsible for the discrepancy. LPN C said he/she was not sure if anyone audits the controlled medication logs but would think the DON audits them periodically. Intake# 3041555