STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A381	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Memorial District Hospital	35629 Highway 72 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 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. Based on interview and record review, facility staff failed to follow professional standards when physical therapy orders were not initiated for one resident (Resident #1). The facility census was 13.1. Review of the facility's policy titled Medication Management: Ordering and Transcribing, dated 03/01/14, showed all medication and treatment orders shall be written in the medical record or entered in the computerized order entry system of the resident and signed by the ordering licensed independent practitioner. All orders for treatment shall include the type of treatment, specific requirements of the treatment and frequency of the treatment.2. Review of Resident #1's Quarterly Minimum Data Sheet (MDS), a federally mandated assessment tool, dated 09/17/25, showed staff assessed the resident as cognitively intact with a diagnosis of paraplegia, (a severe or complete loss of motor function in the lower extremities and lower portions of the trunk), and generalized muscle weakness.Review of the resident's care plan, dated 09/23/25, showed the resident's goal related to paraplegia and general weakness was to remain as independent as possible. Provide restorative care for passive/active range of motion as ordered.Review of the resident's outpatient discharge records, dated 09/29/25, showed an order for physical therapy at least one hour per day, five days per week, for core and bilateral lower extremity strength, range of motion, transfers, and mobility. Review of the resident's physician order summary (POS), dated 10/15/25, showed the orders did not contain an order for restorative care or physical therapy.3. During an interview on 10/14/25 at 4:13 P.M., the resident said at one time he/she received physical therapy, but he/she had not for about a month and a half. The resident said he/she is supposed to get restorative therapy, and he/she is not. The resident said he/she would like additional exercise, especially for his/her upper body, to maintain strength, and become more independent.During an interview on 10/16/25 at 08:45 A.M., Licensed Practical Nurse (LPN) A said the process for activating written clinic orders is to fax the order to the physician's office, and if the physician approves it, a signed order is sent to the facility or a verbal order is received. The order is transcribed to the medical record by nursing staff. LPN A said he/she thought the physical therapy order had been sent to the physician's office, but he/she did not remember receiving a response. During an interview on 10/16/25 at 8:55 A.M., the facility director said when an order is obtained from an outside source the expectation is to contact the facility physician via fax or phone for approval, and he/she did not know if the physician had been contacted. He/She said typically a nurse from the physician's office calls back with a verbal order, which should be transcribed by the nurse who receives it. The director said it looks like the physical therapy order had not been transcribed. He/She said the risks of resident inactivity include skin breakdown, weakness, blood clots and pneumonia. The facility director said when orders are missed, an incident report is written, and education is provided. During an interview on 10/16/25 at 11:08 A.M., the administrator said when new orders are received, the facility physician reviews the orders and determines if they are necessary, and approved orders are relayed to the nursing staff. The administrator said the nursing staff (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and facility director are responsible to follow up on all orders. He/She said gaps in service due to missed orders has the potential to lead to decline in the resident's condition.During an interview on 10/16/25 at 11:20 A.M., the physician said he/she has tried to get the resident physical therapy for a long time. The physician said he/she did not recall receiving a faxed order for the resident's physical therapy, but said if he/she had, it would have been approved. The physician said he/she guarantees this resident will experience a decline in physical and mental status without increased physical activity such as that provided by physical therapy.

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(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 - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide documentation of monthly drug regimen reviews for five (Residents #1, #2, #4, #13 and #15) of five sampled residents. The facility census was 13.1. Review of the facility's policy titled Long Term Care Drug Regimen Review, dated 06/20/22, showed the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This review must include a review of the resident's medical chart.2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/17/25, showed staff assessed the resident as: -Cognitively intact;-Diagnoses of Diabetes, urinary tract infection (UTI) and paraplegia, paralysis of the legs and lower body;-Received opioids; -Received anticoagulants; -Received antibiotics; -Received anti-anxiety medication;-Received insulin injections seven of the past seven days. Review of the resident's medical record showed the record did not contain documentation the pharmacist conducted a medical record review, at least monthly, that included a review of the resident's medical record and/or documentation the pharmacist reported irregularities, if any, to the attending physician, medical director and the Director of Nursing (DON). 3. Review of Resident #2's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact;-Diagnoses of diabetes, coronary artery disease, peripheral vascular disease, renal failure, stroke, anxiety and depression;-Received anti-anxiety medication;-Received anti-depression medication;-Received diuretic medication;-Received opioids;-Received anti-platelet medication. Review of the resident's medical record showed the record did not contain documentation the pharmacist conducted a medical record review, at least monthly, that included a review of the resident's medical record and/or documentation the pharmacist reported irregularities, if any, to the attending physician, medical director and the DON. 4. Review of Resident #4's Significant Change in Status (SCSA) MDS dated [DATE], showed staff assessed the resident as: -Cognitively impaired;-Delusional;-Received pain medication as needed;-Received an antipsychotic, antidepressant and antiplatelet medication;-Diagnoses of heart disease, malnutrition, stroke, dementia, depression, arthritis, and hemiplegia (inability to use one side of body). Review of the resident's care plan dated 08/12/25 directed staff to ensure a pharmacy review is completed monthly. Review of the resident's medical record showed the record did not contain documentation the pharmacist conducted a medical record review, at least monthly, that included a review of the resident's medical record and/or documentation the pharmacist reported irregularities, if any, to the attending physician, medical director and the DON. 5. Review of Resident #13's Quarterly MDS dated [DATE], showed staff assessed the resident as: -Cognitively severely impaired;-Diagnoses of non-traumatic brain dysfunction, heart disease, Alzheimer's disease, anxiety and depression;-Received antipsychotic, antidepressant, anti-anxiety medication. Review of the resident's medical record showed the record did not contain documentation the pharmacist conducted a medical record review, at least monthly, that included a review of the resident's medical record and/or documentation the pharmacist reported irregularities, if any, to the attending physician, medical director and the DON. 6. Review of Resident #15's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively severely impaired;-Diagnoses of non-traumatic brain dysfunction, atrial fibrillation, and Alzheimer's disease;-Received antipsychotic medication. Review of the resident's medical record showed the record did not contain documentation the pharmacist conducted a medical record review, at least monthly, that included a review of the resident's medical record and/or documentation the pharmacist reported irregularities, if any, to the attending physician, medical director and the DON. 7. During an interview on 10/16/25 at 10:45 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A.M., the facility director said the pharmacist chooses a day each month to go through resident charts to review medications prescribed. If a change is recommended, a sheet is filled out and left in the chart. He/She said they are provided no documentation that the review was completed if a change is not recommended. He/She said staff assume reviews are completed as required.During an interview on 10/16/25 at 11:09 A.M. the Administrator said the documentation provided does not indicate the reviews were completed. Staff are expected to complete the pharmacy reviews as required.

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(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. Based on interview and record review, facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. This failure has the potential to affect all residents. The facility census was 17.1. Review of the facility's job description titled Food Service Director dated 04/08/21, showed the purpose of the position is to provide supervision over all dietary functions and staff as directed/instructed, which included assisting in planning, organizing, developing, implementing, and directing the dietary services department, as well as its program and activities, in accordance with current rules, regulations, and guidelines that govern the facility. Review of the food service director's personnel records showed a hire date for the food service director's position listed as 01/27/25. Review showed the records did not contain documentation of prior dietary management experience in a nursing facility and certification or other education required for the director of food and nutrition services position. During an interview on 10/14/25 at 11:00 A.M., the food service director said he/she has been the food service director since January 2025, he/she did not have prior experience as a dietary manager in a nursing facility and he/she did not have a degree or certification related to food service management. The food service director said he/she enrolled in an online certified dietary manager's course on 10/13/25, but he/she had not started the course yet. The food service director said the facility's registered dietician only works part-time and the facility did not have any certified or clinically qualified nutritional staff employed full-time. During an interview on 10/15/25 at 1:43 P.M., the Chief Executive Officer (CEO) said the food service director had been the facility's Director of Food and Nutrition Services since January 2025. The CEO said the facility's registered dietician works part-time and the facility did not have any certified or clinically qualified nutritional staff employed full-time. The CEO said he/she knew the food service director did not have the qualifications required for the Director of Food and Nutrition Services position, but he/she thought they had a grace period to get him/her certified and did not know he/she needed to meet the requirements upon hire.