STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305058	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salemhaven	23 Geremonty Drive Salem, NH 03079

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. Based on observation, interview, and policy review, it was determined that the facility failed to store and serve food in accordance with professional standards for food safety to prevent foodborne illness in 1 of 1 kitchen and 3 of 3 kitchenettes observed. Findings include:Review on 4/23/24 of the U.S. Food and Drug Administration Food Code, dated 2017, retrieved from https://www.fda.gov/food/FDA-food-code/food-code-2017 revealed the following: .Annex 3, Public Health Reasons/Administrative Guidelines . Chapter 3 Food .3-305.11 Food Storage .FOOD shall be protected from contamination by storing the FOOD: . On-premises preparation .(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded .(3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded .; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods . Observation on 8/12/25 at approximately 8:25 a.m. of the walk-in refrigerator in the kitchen revealed the following: one (1) carton of thickened apple juice with no open or use by date; one (1) carton of thickened cranberry juice cocktail with no open or use by date; one (1) carton of thickened orange juice with no open or use by date; one (1) carton of hydrolyte thickened water with a hint of lemon with no open or use by date; one (1) carton of thickened dairy beverage with no open or use by date. Observation on 8/12/25 at approximately 8:35 a.m. of the 2nd floor Unit kitchenette refrigerator revealed two (2) Vital Cuisine Mighty Shakes with no thawed date or use by date. Observation on 8/12/25 at approximately 8:40 a.m. of the 2nd floor Skilled Nursing Unit kitchenette refrigerator revealed eight (8) Vital Mighty Shakes with no thawed date or use by date and one (1) carton of thickened apple juice with no open or use by date.Observation on 8/12/25 at approximately 8:45 a.m. of the 3rd floor Unit kitchenette refrigerator revealed four (4) Vital Cuisine Mighty Shakes with no thawed date or use by date.Interview on 8/12/25 at approximately 8:45 a.m. with Staff G (Dietary Manager) confirmed that the thickened beverages and shakes on the kitchen and kitchenettes should have been labeled with an open and use date based on the manufacturer's instructions.Review on 8/12/25 of the manufacturer's instructions for Vital Cuisine Mighty Shakes under storage and handling revealed .Store frozen. Use thawed product within 14 days. Keep Refrigerated .Review on 8/12/25 of the manufacturer's instructions for Thick & Easy Thickened Orange Juice, Apple Juice, Cranberry Juice, and Hydrolyte Lemon Water under storage and handling revealed .Discard if not used within 10 days of opening .Review on 8/12/25 of the manufacturer's instructions for Thick & Easy Thickened Dairy Beverage under storage and handling revealed .Discard if not used within 4 days of opening .Review on 8/12/25 of the facility's policy titled Food Labeling,with no date, revealed 1. Any product that is unopened, go by manufacturers use by date.4. Mighty shakes are to be labeled with an (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expiration date, 14 days after they are taken out of the freezer. This includes shakes used on the tray line, stocked on the floors or stored in the walk-in .

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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, it was determined that the facility failed to ensure that physician's orders were followed for 1 of 5 residents reviewed for choices in a final sample of 19 residents. (Resident identifier is #84.)Findings include: Review on 8/13/25 of Resident #84's August 2025's MAR (Medication Administration Record) revealed:Labetalol HCL (Hydrochloric Acid) Oral Tablet (Labetalol HCL) Give 100 mg (milligrams) by mouth every 6 hours for HTN (Hypertension) (Give if SBP (Systolic Blood Pressure) greater than 160, Hold if AP (Apical Pulse) less than 60), Start Date 8/1/25 revealed: 8/3 the medication was administered at 8:00 am with a SBP of 121, at 2:00 p.m. with a SBP of 137, and 8:00 p.m. with a SBP of 134.8/6 the medication was administered at 8:00 p.m. with a SBP of 128.8/7 the medication was administered at 2:00 a.m. with a SBP of 139.8/8 the medication was administered at 2:00 a.m. with a SBP of 141.8/9 the medication was administered at 8:00 a.m. with a SBP of 152, and at 2:00 p.m. with a SBP of 142.8/10 the medication was administered at 2:00 p.m. with a SBP of 143 and at 8:00 p.m. with a SBP of 145.Interview on 8/13/25 at approximately 11:45 a.m. with Staff D (Infection Preventionist) confirmed that the check in the MAR indicates the medication was administered outside of the parameters that were ordered. Interview on 8/13/25 at approximately 12:15 p.m. with Staff C (Doctor of Medicine) revealed that Staff C would not expect the medication to be administered outside of the parameters that were indicated on the order.Review on 8/14/25 of the facility policy titled, Medication Administration (General Guidelines), Dated 1/25 revealed: . Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. Documentation: . 2. If a dose of regularly scheduled medication is withheld . the nurse shall document either in the Electronic Medication Administration Record or the paper MAR that the dose was withheld, . and enter an explanatory note .

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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. Based on interview and record review, it was determined that the facility failed to ensure that residents received the appropriate care and services for catheter care for 2 of 2 residents reviewed for urinary catheters in a final sample of 19 residents. (Resident identifiers are #1and #5).Findings include:Resident #1 Review on 8/12/25 of Resident #1's physician orders revealed the following: Irrigate Foley/Suprapubic Catheter with normal saline PRN [as needed] per MD [Doctor of Medicine] orders (SPECIFY), dated 7/14/25. Further review revealed that there were no other orders indicating when to irrigate Resident #1's foley catheter and no orders for how much normal saline to use when flushing Resident #1's foley catheter. Review on 8/12/25 of Resident #1's care plan, initiated on 7/15/25 revealed that Resident #1 had an indwelling catheter due to his/her diagnosis of urinary retention. Further review revealed that under interventions included .Report to MD (Doctor of Medicine) no output . Review on 8/12/25 of Resident #1's medical record revealed there was no urine output documented between 8/9/25 at 10:22 p.m. and 8/10/25 at 6:15 a.m. Further review revealed that there was no documentation that a provider was notified that Resident #1 had no urine output reported on 8/10/25 at 6:15 a.m. Interview on 8/13/25 at 12:45 p.m. with Staff I (Unit Manager) confirmed that a provider was not notified on 8/10/25 that Resident #1 had no urine output during the overnight. Resident #5 Review on 8/12/25 of Resident #5's physician orders revealed the following order: Irrigate Foley/Suprapubic Catheter with normal saline PRN (as needed) per MD (Doctor of Medicine) orders (SPECIFY), dated 7/17/25. Further review revealed that there were no other orders indicating when to irrigate Resident #5's foley/suprapubic catheter and no orders for how much normal saline to use when flushing Resident #5's foley/suprapubic catheter. Interview on 8/13/25 at approximately 12:25 p.m. with Staff A (Director of Nursing) confirmed the order to irrigate Resident #1 and Resident #5's foley/suprapubic catheter did not have clear indications for when to perform catheter irrigation. Interview on 8/13/25 at approximately 12:30 p.m. with Staff C (Doctor of Medicine) confirmed that Resident #1 and Resident #5's order to irrigate his/her foley/suprapubic catheter did not have indications needed for a complete order. Interview further revealed that Staff C was not notified that Resident #1 had no urine output at 8/10/25 at 6:15 a.m. Review on 8/14/25 of the facility policy titled, Medication Orders, Non-Controlled Medication Orders, Dated 1/23 revealed: . Elements of The Medication Order: . i. Indication for use if ordered PRN. 3. PRN orders shall specify the condition for which they are being administered, for example, as needed for pain Documentation of The Medication Order: . C. A designated nurse reviews the order summary for any necessary corrections. This is done on a routine basis per regulation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, it was determined the facility failed to properly label a vial of multidose injectable medication when opened for 2 out of 3 medication refrigerators observed.Findings include:Observation on 8/13/25 at 8:40 a.m. of the third floor medication room refrigerator revealed an open vial of Tuberculin Purified Protein Derivative that was unlabeled with an opened date or an open expiration date. Interview on 8/13/25 at 8:40 a.m. with Staff E (Licensed Practical Nurse) confirmed the above findings. Observation on 8/12/25 at approximately 9:10 a.m. in the Infection Preventionist Office refrigerator revealed one opened undated vial of Tuberculin solution. Interview on 8/12/25 at approximately 9:10 a.m. with Staff D (Infection Preventionist) confirmed the above findings. Review on 8/13/25 of manufacturer's instruction for Tuberculin Purified Protein Derivative revealed: A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. Do not use after expiration date. Review on 8/13/25 of the facility's policy titled Section 3.7 Medications and Medication Labels dated 1/25 revealed, 2. Multi-dose vials shall be labeled to assure product integrity, considering the manufacturers'; specifications. (Example: Modified expiration dates upon opening the multi-dose vial.). Nursing staff should document the date opened on multi-dose vials on the attached auxiliary label.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to conduct an annual review of its infection prevention and control program and implement policies and procedures for Transmission Based Precautions (TBP) to prevent the potential spread of infection for 3 of 4 resident observed for TBP in a final sample of 19 residents. (Resident identifier is #17, #56, and #68.). Findings include:Interview on 8/12/25 at 8:30 a.m. with Staff J (Licensed Practical Nurse) revealed that there was an upper respiratory virus outbreak and the following residents were on contact precautions: Resident #17, Resident #56, and Resident #68. Interview 8/12/2025 at 12:30 p.m. with Staff D (Infection Preventionist) confirmed that rooms Resident #17, Resident #56, and Resident #68 were on droplet precautions recommended by the health department due to a respiratory outbreak at the facility. He/she stated that residents that were symptomatic should remain on droplet precautions until they had completed their antibiotics or symptomatic free for 24 hours. Staff D stated that all staff who entered a room on droplet precautions should wear a N95 mask, gloves, gowns, and a face shield. Resident #68 Review on 8/12/25 of Resident #68's care plan, revised on 8/12/25 revealed that Resident #68 had pneumonia. Further review revealed that under interventions included Droplet Precautions. Observation on 8/12/25 at 9:59 a.m. of Resident #68's room revealed droplet precaution PPE signage outside of Resident #68's room. The sign indicated that an N95, gloves, gowns and a face shield should be worn. Observation further revealed Staff K (Contracted Dermatologist) was in Resident #68's room and he/she was wearing only a surgical mask and a gown. Staff K exited Resident #68's room and doffed his/her gown. Interview on 8/12/25 at 10:00 a.m. with Staff K confirmed the above findings. Resident #17 Observation on 8/12/25 at 11:01 a.m. of Resident #17's room revealed a droplet precaution and PPE signage was posted at the doorway. Staff L (Social Worker for Hospice Company) was seated inside Resident #17's room, Staff L was not wearing any PPE. Further observation revealed that Staff L exited Resident #17's room. Interview on 8/12/25 at 11:10 a.m. with Staff L confirmed the above findings. Resident #56 Review on 8/12/25 of Resident #56's medical record revealed that Resident #56 continued on antibiotic therapy for an upper respiratory infection and was placed on droplet precautions on 8/6/25. Observation on 8/12/25 at 12:18 p.m. of Resident #56's room revealed a droplet precaution PPE sign posted at the doorway. Observation further revealed Staff M (Licensed Nursing Assistant) entered Resident #56's room with his/her meal tray. Staff M remained in Resident #56's while he/she helped Resident #56 with meal set up. Staff M exited the room and was wearing a surgical mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/12/25 at approximately 12:20 p.m. with Staff M confirmed that he/she was wearing a surgical mask only and that he/she would wear an N95 mask, gloves, gown, and a face shield to provide care for residents on droplet precautions. Review on 8/13/25 of the facility's Infection Prevention and Control Plan 2024 dated 6/22/24, revealed, Infection Prevention and Control Plan . The facility's risk assessment is done at least annually . Each goal has at least one measurable objective that is evaluated annually .Policies and Monitoring . Transmission-based Precautions: The CDC's guidelines for Transmission-based Precautions also known as Isolation Precautions will be followed. Transmission-based Precautions are designed for patient/resident known or suspected to infected or colonized with highly transmissible or epidemiologically significant pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission within the facility. Transmission-based Precautions will be followed by all employees per policy . Review on 8/14/25 of the facility's policy titled Isolation Precautions and last revised on 6/20/23 revealed, .Droplet Precautions- In addition to standard precautions, use droplet precautions for a resident known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident sneezing, coughing, talking, etc., and drip from the air . III. Inform all staff members for the need for isolation Precautions A. Explain procedure that must be initiated and maintained B. Provide education as appropriate IV Gather equipment A. Obtain isolation cart and place on outside of door with a 24-hour supply of masks, gowns, etc. needed to maintain isolation Precautions . V. Notify other departments that resident is on isolation precautions . 7. All personal protective equipment (disposable isolation gowns, mask, gloves, etc.) should be used once and discarded in the trash receptacle and linen placed in soiled linen bucket . Interview on 8/13/25 at 1:12 p.m. with Staff D (Infection Preventionist) revealed that the facility followed the CDC guidelines for Transmission-Based Precautions to develop their procedures. Interview on 8/14/25 at 10:22 a.m. with Staff F (Administrator) confirmed that the above Infection Prevention and Control Plan 2024 had not been reviewed since June 2024.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, it was determined that the facility failed to implement policies and procedures on COVID-19 immunization for 1 of 1 staff reviewed for COVID-19 immunizations. (Staff identifier is Staff M).Findings include: Review on 8/14/25 of the facility's policy titled COVID-19 Vaccination implemented on 8/12/25 revealed, . It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 . by education and offering our residents and staff the COVID-19 vaccine . Up-to-date is defined as receiving a 2024-2025 updated COVID-19 vaccine . 14. The facility will educate and offer the COVID-19 vaccine to residents, resident represents and staff and maintain documentation of such. 15. The facility will maintain documentation related to staff COVID-19 vaccination and include at a minimum: a. Education to the staff regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. The offering of the COVID-19 vaccine or information on obtaining the COVID-19 vaccine; c. The COVID-19 vaccine status of staff and related information . Interview on 8/13/25 at 3:10 p.m. with Staff D (Infection Preventionist) revealed that the facility does not offer COVID-19 vaccinations to employees or track/obtain a declination. Staff D revealed that there was no policy for COVID-19 immunization for staff. Review on 8/13/25 of Staff M immunization Report Card revealed that Staff M last COVID-19 vaccination was 12/13/21. Interview on 8/14/25 at 8:45 a.m. with Staff M revealed that they could not recall when the facility had last offered them the COVID-19 vaccination. Staff M confirmed that he/she had not been asked to sign a declination that they had been educated and refused the COVID-19 vaccination. Review on 8/13/25 of the facility's Infection Prevention and Control Plan 2024 dated 6/22/24, revealed, .A number of vaccinations are available to patients/residents and employees by physician order or upon request with a physician's order .Employee influenza vaccinations will be offered during flu season Further review revealed that this plan did not address COVID-19 vaccinations for staff. Interview on 8/13/2025 at 12:45 p.m. with Staff D revealed the above plan was the only policy for COVID-19 vaccination. Interview on 8/14/25 at 10:22 a.m. with Staff F (Administrator) confirmed that the above Infection Prevention and Control Plan 2024 had not been reviewed since June 2024.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, it was determined that the facility failed to demonstrate their response and rationale to resident council grievances for May and June 2025 and maintain evidence demonstrating the response and rationale of the resident group grievances from the Resident Council Meeting. Findings include: Review on 8/12/25 of the facility's Resident Council Meeting minutes revealed the following:On 5/13/25 there were concerns that food was not hot and there were missing items (blanket and two afghans);On 6/9/25 there were concerns of cold meals; food was not what was ordered and the wait times for using the bathroom were too long. On 7/24/25 there were concerns that residents were waiting too long to use the bathroom, there were missing items (did not specify what items were missing) and food was served cold, delivered late and was not what was ordered.Further review of the above three meeting minutes revealed that there was no documentation that concerns were responded to or followed up on at the next Resident Council Meeting. There were no Resident Council Meeting minutes for the months of February, March or April 2025 for review. Interview on 8/12/25 at 12:48 p.m. during Resident Council Meeting revealed that all eight members in attendance agreed that the facility did not inform them of what, if any, actions had been taken regarding concerns/grievances that were discussed during previous Resident Council Meetings. Further interview revealed that all eight members attended Resident Council regularly. Interview on 8/13/25 at 10:31 a.m. with Staff H (Activity Director) revealed that he/she attended Resident Council Meetings and confirmed that concerns/grievances were not responded. Staff H revealed that he/she did not share the above concerns from June and July with the Department Heads. Interview on 8/13/25 at 10:52 a.m. with Staff F (Administrator) confirmed that concerns were not documented as being followed up on. Staff F also confirmed that Resident Council was not held in February and March 2025, and that they could not find the minutes from April 2025. Review on 8/14/25 of the facility's undated policy titled Resident Council Meeting revealed, .The resident council agenda should include the following . Resident Rights . Grievance Procedure . Minutes of last Meeting . Procedure . 3 The AD [Activities Director] or Designee will facilitate follow-up on all concerns, complaints, suggestions and ideas presented at the council meeting and will report results at the next meeting for the residents' information. This information will be included in the minutes .6. Each department and or department manager will be responsible for follow up and completion of a response form to address the resolution prior to the next meeting. 7. Always ask the council fi they would like any department directors to attend the next month's meeting i.e. food service director if there was any concerns or questions with food or meal service . 10. The minutes for each of the month's meetings will be kept on file in the Activity Director's office or Administrator/Executive Directors' office . 13. The meeting minutes should be reviewed by the Administrator each month to ensure appropriate and timely follow up .