STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365480	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residence at Salem Woods	6164 Salem Road Cincinnati, OH 45230

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, staff interview, and review of the facility policy, the facility failed to obtain a resident's weight upon admission to the facility. This affected one (#16) resident of the three residents reviewed for weight changes. The facility census was 84 residents. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including diabetes mellitus (DM), dysphagia, and acute kidney failure. Review of the care plan for Resident #16 dated 03/15/25 revealed the resident was at risk for alteration in nutrition and hydration and weight loss related to acute kidney failure, hydronephrosis, DM, fatty liver, anemia and poor intakes. Interventions to prevent weight loss included the following: assist/feed meals, monitor laboratory findings as ordered, speech referral as needed, provide supplements as ordered. Review of the Minimum Data Set (MDS) assessment for Resident #16 dated 04/24/25 revealed the resident had impaired cognition and required maximum assistance from the staff with eating. Review of the weight record for Resident #16 revealed a weight of 186.1 pounds on 03/15/25 and a weight of 152.4 pounds on 03/21/25. The Registered Dietitian (RD) crossed out the admission weight of 186.1 pounds dated 03/15/25 and documented the weight as inaccurate. Interview on 04/30/25 at 12:32 P.M. with the RD confirmed she documented Resident #16's admission weight of 186.1 as erroneous. The RD confirmed she spoke Registered Nurse (RN) #38 who stated the facility staff did not obtain Resident #16's weight upon admission but had copied the weight of 186.1 from preadmission hospital records. Interview on 04/30/25 at 1:28 P.M. with RN #38 confirmed she completed the admission assessment for Resident #16 on 03/15/25 but the facility staff did not obtain a weight for the resident. RN #38 confirmed she copied the weight from the resident's preadmission hospital paperwork. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) and the RD on 04/30/25 at 3:07 P.M. confirmed facility staff should obtain an actual resident weight upon admission and note the weight in the medical record. The DON and the RD further confirmed the facility did not obtain a weight for Resident #16 upon admission. Further interview confirmed RN #38 copied the admission weight of 186.1 for Resident #16 from the preadmission hospital paperwork and the staff had not actually weighed the resident. Review of the facility policy titled Admission Weights undated revealed residents must have accurate admission weights, and the facility staff should weigh the resident upon admission using a standing scale, a sitting scale or a Hoyer scale. Staff should not use the hospital weight, or a weight reported by the resident.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51523 Based on medical record review, observation staff interview, review of the facility policy, and review of guidelines from the National Pressure Injury Advisory Panel (NPIAP), the facility failed to ensure resident pain was effectively managed during a dressing change. This affected one (Resident #6) of three residents reviewed for pain management. The facility census was 84 residents. Findings include: Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including diabetes, profound intellectual disabilities, anxiety disorder, and aphasia. Review of the care plan for Resident #6 dated 12/28/11 revealed the resident was unable to verbally express pain. Goals of Resident #16's care plan were to decrease the resident's pain to an acceptable level to allow the resident's participation in treatments and activities of daily living (ADLs) and signs of discomfort would be reduced or resolved. Interventions included the following: administer medications as ordered, medications as ordered to manage pain, monitor effectiveness of interventions, monitor for increased pain levels. Review of the Minimum Data Set (MDS) assessment for Resident #6 dated 02/07/25 revealed the resident was non-communicative with severely impaired cognition and was dependent on staff with all activities of daily living (ADLs). Review of the notes per the wound nurse practitioner (NP) for Resident #6 dated 04/10/25 revealed the resident had a full thickness diabetic foot ulcer to his left heel which measured 3.3 centimeters (cm) in length by 3.5 cm in width with the depth unable to be determined. The ulcer contained 30 percent (%) granulation tissue, 20 % slough, and 50 % eschar. Debridement of the wound was postponed due to concerns for Resident #6's discomfort and pain levels. The treatment was changed due to adherence of the dressing to the wound bed to the following order: cleanse the wound with normal saline, apply Medihoney, apply calcium alginate, cover with an ABD pad and wrap with Kerlix. Review of the notes per the wound NP for Resident #6 dated 04/17/25 revealed the resident's diabetic foot ulcer measured 4.2 cm in length by 4.0 cm in depth with a depth unable to be determined. The ulcer contained 10 % granulation tissue, 10 % slough, and 80 % eschar. The resident showed signs of discomfort and pain to the ulcer during the wound NP visit. Review of the Medication Administration Record (MAR) for Resident #6 dated April 2025 revealed the resident had an order for Tramadol twice daily as needed for pain. Resident #6 was not documented for administration of Tramadol on 04/30/25. Observation of wound care for the left diabetic foot ulcer for Resident #6 on 04/30/25 at 9:27 A.M. per Assistant Director of Nursing (ADON) #97 revealed when the nurse began removing the dressing from the resident's left foot, the resident attempted to pull his foot away. As ADON #97 continued with dressing change Resident #6 began whimpering, pulling his foot away, grimacing, moaning and growling in pain, and began biting his fingers and these signs continued throughout the procedure. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/25 at 9:50 A.M. with ADON #97 confirmed she was unaware if Resident #6 had received pain medication prior to the dressing change and confirmed the resident demonstrated signs of pain and discomfort throughout the procedure such as pulling his foot away, grimacing, moaning and growling in pain, and biting his fingers. ADON #97 confirmed she continued with the treatment despite Resident #6 exhibiting nonverbal indicators of pain. Review of the facility policy titled Pain Assessment and Management dated 03/31/16 revealed assessment and adequate treatment of pain was central to the management of the physical and psychological well-being of residents. The resident's pain should be assessed as needed and if the resident was unable to communicate pain symptoms, the staff should observe for behavior that indicated pain such as restlessness, agitation, groaning or holding of an area. The staff should provide pharmacological interventions in accordance with physician's orders. Review of the online resource per the NPIAP titled Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline at (https://npiap.com/general/custom.asp?page=2014Guidelines) downloaded on 05/14/25, revealed on page 161 that staff should organize care delivery to ensure that it is coordinated with pain medication administration and that minimal interruptions follow. Pain management included performing care after administration of pain medication to minimize pain experienced and interruptions to comfort for the individual. Review of page 165 revealed staff should use adequate pain control measures, including additional dosing, prior to commencing wound care procedures. This statement was based on expert opinion. Wound care procedures including wound manipulation, wound cleansing, debridement, and dressing changes were painful to the patient.