STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366096	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem West Healthcare Center	2511 Bentley Drive Salem, OH 44460

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of the self-reported incident (SRI) tracking number 250524, facility SRI investigation, medical record review, interviews, and facility policy review, the facility failed to prevent staff-to-resident physical abuse for Resident #34. This affected one resident (#34) of three residents reviewed for abuse. The facility census was 56. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, unspecified dementia with agitation, hypothyroidism, benign prostatic hyperplasia, ulcerative colitis, presence of an automatic implanted cardiac defibrillator, rheumatoid arthritis, weakness, and cognitive communication deficit. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 08/07/24 revealed Resident #34 had severely impaired cognition and was dependent for eating, toileting hygiene, bathing, and transfers. Further review of the MDS revealed Resident #34 had complex medical conditions and non-Alzheimer's dementia. Review of the care plan dated 07/15/24 revealed Resident #34 had communication problems due to impaired cognition and had a mood and behavior problem. Interventions included allowing adequate time for responses, not rushing care or conversation, making eye contact, reducing environmental noises, providing consistency, allowing the resident to make informed decisions, supporting and honoring the resident's preferences and choices, and providing education as needed. Further review of the care plan revealed Resident #34 used mood stabilizing medication and staff were to maintain a consistent daily routine, observe for behaviors, limit over-stimulation, and provide a calm environment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 08/07/24 revealed that at 5:02 A.M. Assistant Director of Nursing (ADON) #329 was notified by phone by the floor nurse that there was an altercation between Resident #34 and a staff member. The floor nurse was directed to assess Resident #34 for injuries, which had been completed with a small pink area noted on Resident #34's left cheek. The floor nurse was instructed to gather witness statements and send the state tested nurse aide (STNA) involved in the incident (STNA #312) home. Review of this progress note further revealed ADON #329 arrived at the facility at 6:00 A.M., followed-up with the resident and potential witnesses, completed a head-to-toe assessment of Resident #34, and notified the family, physician/medical director, and police of the incident. Resident #34 had no recollection of the alleged incident, and the spouse of Resident #34 declined to press charges against STNA #312. Review of the social services progress note dated 08/07/24 revealed Social Services Designee (SSD) #355 attempted to assess Resident #34's psychosocial status, but Resident #34 had no recollection of the incident. Review of the social services note dated 08/08/24 revealed SSD #355 arranged for counseling for Resident #34, and the therapist stated that Resident #34 was unable to participate in the evaluation due to confusion and cognitive impairment. Interview with Resident #34 was unable to be conducted during the on-site SRI review on 09/03/24 due to the resident passing away under the care of Hospice services on 08/31/24. Interview on 09/03/24 at 3:35 P.M with Licensed Practical Nurse (LPN) #318 confirmed she was on duty on 08/07/24 when STNA #350 approached her, followed by STNA #312, to report Resident #34 struck STNA #312 in the face, and STNA #312 struck him back. During the interview, LPN #318 confirmed she immediately assessed Resident #34 and described her findings as his face was beet red with a mark on the side of his face. Resident #34 would not speak to her, which LPN #318 reported was unlike him. LPN #318 further confirmed she notified the other nurse on duty, spoke with ADON #329 for further instruction, obtained witness statements, and directed STNA #312 to leave the premises. At the time of the interview, LPN #318 said that STNA #350 reported to her that STNA #312 struck Resident #34 more than once but was unable to provide further detail. Review of the facility incident log revealed an incident of alleged abuse for Resident #34 was logged on 08/07/24. Review of the facility's SRI investigation written witness statements from LPN #318, STNA #312, and STNA #350 revealed supportive statements by each that Resident #34 made physical contact with the face of STNA #312 and she reacted by striking him back. The witness statements from other STNAs on duty that shift revealed no knowledge to support or rebuke the alleged abuse incident. Review of the skin grid non-pressure assessment completed on 08/07/24 revealed Resident #34 had a pink area on his left cheek measuring 1.5 centimeters (cm) by 1.0 cm by 1.5 cm and his left eye was pink with yellow discharge and irritation. Review of the facility's SRI investigation findings revealed the facility substantiated the abuse stating STNA #312 struck Resident #34, but did not conclude with certainty the reddened area on Resident #34's cheek was a direct result of being struck by STNA #312 due to a concurrent diagnosis of conjunctivitis of the left eye. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/03/24 at 4:45 P.M. with the Director of Nursing (DON) confirmed STNA #312 was suspended immediately pending investigation findings and had not returned, and indicated she is no longer employed by the facility. The DON further confirmed all staff were educated on the abuse policy and how to properly provide care to residents who displayed aggressive behaviors. Interview on 09/03/24 at 4:55 P.M. with the Executive Director (ED) and ADON #329 confirmed STNA #312 was no longer working at the facility and resigned in lieu of termination. During the interview, Resident #34's history of dementia with behaviors was confirmed with a history of striking toward staff but never making physical contact with his strikes. The Executive Director and ADON #329 also confirmed house-wide training was completed on the abuse policy and handling aggressive behaviors, and that additional re-education was provided to the nursing staff on checking resident Kardex's prior to rendering care. The ED also provided confirmation the facility completed staff and resident audits related to abuse and had an ad hoc quality assurance and performance improvement (QAPI) meeting, as well as daily clinical meetings, where the administrative team discussed audit findings. The ED also confirmed a behavioral specialist came to the facility on [DATE] and completed behavior health training to reinforce previous education related to the care of residents with behaviors. Interview on 09/03/24 with the DON at 5:00 P.M. confirmed weekly audits of five staff and five residents related to abuse commenced right after the reported incident on 08/07/24, and he had completed four consecutive weeks of the audits which revealed no concerns of abuse. Interviews on 09/03/24 at 5:25 P.M with Regional Director of Clinical Services (RDOCS) #335 confirmed an ad hoc meeting was held on 08/21/24 where the reported incident and plan of compliance was discussed, and she had visited the facility several times since the incident and reviewed audit progress and interacted with staff and residents with no further concerns noted. On 09/03/24 at 5:30 P.M., the ED confirmed the abuse policy had been reviewed as a part of the QAPI oversight and no changes were made to the policy. Review of the facility policy titled OHIO Abuse, Neglect, and Misappropriation, effective as of 03/06/24, revealed the facility implemented policies and procedures to screen, prevent, assess, educate, and report all types of abuse, neglect, misappropriation, and exploitation. The deficient practice was corrected on 08/08/24 when the facility implemented the following corrective actions: STNA #312 was suspended immediately and after the investigation concluded, STNA #312 voluntarily resigned in lieu of termination as of 08/15/24. Resident #34 was assessed by LPN #318 and report was called to ADON #329 on 08/07/24 at 5:02 A.M. Witness statements were obtained from staff on 08/07/24. Resident #34 was not contributory to the interview attempt by LPN #318 on 08/07/24. ADON #329 performed skin assessment on Resident #34 at 6:00 A.M. on 08/07/24. Notifications were made to the resident's family, the Medical Director, who was the physician of record, and to the local Police Department on 08/07/24 between 6:00 A.M. and 6:40 A.M. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A police report was taken on-site by the local Police Department on 08/07/24 at 6:45 A.M., report incident number 20244027. The DON completed a pain assessment, determining Resident #34 had no indicators of pain on 08/07/24 at 7:48 A.M. Skin assessments were completed with no negative findings on 08/07/24 on all residents who were not interviewable by the RDOCS #335 on 08/07/24. Interviews were conducted on all residents in the facility by SSD #355 throughout 08/07/24 and 08/08/24 with no negative findings. Resident #34 was offered psychosocial support on 08/07/24 and 08/08/24 from the SSD and offered psychiatric services and counseling on 08/08/24. Resident #34 had no recollection of the incident and was non-contributory to offers of support. Facility-wide, all staff training was completed during multiple sessions and via telephone on 08/07/24 on the abuse policy and handling aggressive behaviors. Nursing education was completed on 08/07/24 on reviewing the Kardex for pertinent information before providing resident care. Training sessions were conducted by multiple managerial staff to their respective departments and included RDOCS #335, ADON/RN #329, Culinary Director #323, and Activities Director #351. Weekly resident audits of five residents regarding abuse and safety commenced on 08/08/24 RDOCS #335 and continued weekly by the DON or designee. Weekly staff audits regarding knowledge of abuse and reporting commenced 08/08/24 by RDOCS #335 and continued weekly by the DON or designee. An Ad hoc QAPI meeting took place on 08/21/24 to review quality concerns and the facility's plan of compliance and audit progress related to this incident. Week four of staff and resident abuse audits were completed on 08/27/24 with plan to continue random audits until compliance confirmed with subsequent QAPI meetings. RDOCS #335 will continue to make monthly facility visits for three months and as needed to monitor compliance. Results of the above audits will be reviewed monthly for three months and as needed by the QAPI Committee and revisions/changes will be made to compliance monitoring as deemed necessary by the QAPI Committee. STNA #312 was reported to the Nurse Aide Registry on 09/04/24. This violation was an incidental finding identified during the complaint investigation.

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F 0697 Level of Harm - 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** 48567 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure Resident #13's pain was addressed in a timely and appropriate manner. Actual harm occurred on 08/17/24 when Resident #13, who had an open reduction and internal fixation (ORIF) surgery of a left femur fracture on 08/02/24, was admitted to the facility and the facility failed to develop and implement a comprehensive, individualized and adequate pain management program to provide effective and timely pain relief. Resident #13 displayed signs of pain on admission, during therapy evaluations on 08/19/24 with an increase in severity prior to direct care on 08/20/24 and received no pain interventions. Actual harm continued when Resident #13 was readmitted to the facility on [DATE] without an order for pain medication, exhibited acute pain on 09/01/24, and received no pain medication or interventions until the evening of 09/02/24. This affected one resident (#13) of three residents reviewed for appropriate and timely response to medical condition. The facility census was 56. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including status post ORIF to the left femur, Alzheimer's disease, metabolic encephalopathy, cognitive communication deficit, severe protein-calorie malnutrition, history of falling, acute respiratory failure, dysphagia, and attention to gastrostomy. Review of the admission nurses progress note dated 08/17/24 at 4:10 P.M. revealed Resident #13 was admitted to the facility after recent ORIF of her left femur. The note further described Resident #13 as very restless and agitated with multiple skin tears to her bilateral upper extremities, three incision sites to her left hip with staples, and a large bruise down the back of her left upper leg. Review of the baseline care plan dated 08/17/24 revealed Resident #13 had complaints of acute and chronic pain or was at risk for pain. Interventions included a pain assessment on admission, re-admission, quarterly, with significant changes and as needed. Other interventions included assessing for pain every shift, following physician orders for complaints of pain, and administering non-pharmacological interventions for pain. Review of the admission physician's orders dated 08/17/24 revealed no orders for pain medications or interventions for pain control. Review of the Functional Abilities and Goals - Admission assessment completed 08/19/24 revealed Resident #13 was dependent on others for daily self-care. Review of the progress note dated 08/19/24 at 4:30 A.M. revealed Resident #13 was restless. There was no documentation of interventions related to Resident #13's restlessness in any of the progress notes. There was no documented evidence the physician was notified of Resident #13's restlessness. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the physical therapy (PT) notes from the initial evaluation visit dated 08/19/24 revealed Resident #13 had left hip pain at an intensity of five out of ten on the numeric pain scale, both at rest and with movement, the intensity was determined through resident verbalization, and the pain limited Resident #13's functional abilities. The evaluation also stated Resident #13 had interdisciplinary team (IDT) interventions listed including medications on a scheduled regimen and received medication as needed. (There was no scheduled pain medications ordered). There was no documented evidence that PT notified nursing of Resident #13's pain. Review of the occupational therapy (OT) initial evaluation visit note dated 08/19/24 revealed Resident #13 had pain rated at the intensity level of five out of 10 as determined by facial cues at rest and with movement. Further review of the OT evaluation revealed Resident #13's pain limited her functional abilities, and the interdisciplinary team (IDT) intervention was listed as Unknown. There was no documented evidence that PT notified nursing of Resident #13's pain. Observation on 08/20/24 at 2:05 P.M. revealed a visitor left the room of Resident #13 and informed State tested Nurse Aide (STNA) #340 that Resident #13 was acting like she was in pain. Review of the physician orders on 08/20/24 at 3:50P.M. revealed there were no orders for pain medication. Observation on 08/20/24 from 2:10 P.M. to 2:25 P.M. of incontinence care for Resident #13 performed by STNA #340 revealed Resident #13 was restless, agitated, moaning, had facial grimacing, and was pulling at her percutaneous endoscopic gastrostomy (PEG) tube and bed linens before, during, and after care. Observations further revealed Resident #13 had an increase in vocalizations/moaning and in muscle tone during the incontinence care. During the observed incontinence care, STNA #340 stated She is in severe discomfort, also noting that this behavior was uncommon for Resident #13. Observation after incontinence care on 08/20/24 revealed STNA #340 informed Licensed Practical Nurse (LPN) #322 that Resident #13 was demonstrating signs of pain. Interview on 08/20/24 at 2:30 P.M. with STNA #340 confirmed she was informed by a family member that Resident #13 was exhibiting signs of pain prior to performing incontinence care. Interview on 08/20/24 at 3:27 P.M. with Regional Director of Clinical Services (RDOCS) #335 confirmed once STNA #340 was informed by family that Resident #13 was in pain, she should have informed the nurse and made sure her pain was addressed prior to proceeding with the care. Review of the medical record revealed a primary health care provider telehealth encounter occurred at 10:29 P.M. on 08/20/24 for report of Resident #13 grimacing in pain. Further review of the note revealed the plan was to order Acetaminophen 325 milligrams (mg) (analgesic) two tablets every six hours as needed for pain. Review of the medication administration record (MAR) for August 2024 revealed the nurses documented they monitored for pain twice daily on days and nights from day turn on 08/18/24 through day turn on 08/19/24 by documenting a checkmark. There was no numerical pain scale. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the August 20024 MAR revealed Resident #13 received zero doses of Acetaminophen and zero non-pharmacological interventions in August 2024. No other pain medications were ordered or given for discomfort in the month of August. Review of the Nurse Practitioner (NP) progress note dated 08/21/24 at 3:17 P.M. stated, nursing notified me of abnormal labs for Resident #13. The resident was not seen today; however, after chart review, will send patient to emergency department (ED) for severe leukocytosis (high white blood cell count), hyperbilirubinemia/transaminitis (high liver enzymes). High concern for sepsis/MODS (multiple organ dysfunction syndrome). Review of the Medicare five day/Discharge with Return Not Anticipated (DRNA)/End of PPS Part A Stay Minimum Data Set (MDS) assessment completed on 08/21/24 revealed Resident #13 had severely impaired cognition and had a primary medical condition listed as fractures and other multiple traumas. Further review of the MDS revealed Resident #13 exhibited facial expressions, which could include grimaces, winces, wrinkled forehead, or furrowed brow, one to two of the days during the five-day look-back period and was on no scheduled pain regimen, received or was offered and declined any as needed pain medications, and received no non-pharmacological interventions. Review of Resident #13's clinical census revealed she returned to the facility on [DATE]. Review of the electronic medication administration record (eMAR) progress notes revealed Resident #13 received lorazepam 0.5 milligrams (mg) (antianxiety) via PEG tube for restlessness and agitation on 09/01/24 at 8:29 A.M. and that the lorazepam dose was deemed ineffective on 09/01/24 at 12:46 P.M. as evidenced by documentation of continued restlessness, agitation, and pushing the nurse's hands away during the vital sign assessment. A follow-up review of the physician orders revealed Resident #13 received a new order on 09/02/24 for Acetaminophen 325 mg, two tablets via PEG tube every six hours as needed for pain and that the previous order for Acetaminophen initiated on the evening of 08/20/24 was discontinued when Resident #13 was transferred to the hospital on 08/21/24 and not reordered upon her return to the facility on [DATE]. Interview on 09/03/24 at 11:38 A.M. with Registered Nurse (RN) #364 confirmed he contacted the provider for a telehealth visit to obtain an order for an as needed (PRN) pain medication at the direction of the Director of Nursing (DON) by telephone at approximately 10:30 P.M. on 08/20/24 (eight hours after the nurse was notified the resident was in pain) and, to his knowledge, there had been no other communications with the medical provider regarding Resident #13's pain prior to that interaction. Interview on 09/03/24 at 3:45 P.M. with the sister of Resident #13 confirmed she had visited Resident #13 on 08/20/24 and was concerned that Resident #13 was acting as if she were in severe pain due to her moaning and groaning, increased restlessness, drawing her legs up, and grabbing at her chest and abdomen. During the interview, the resident's sister verbalized Resident #13 looked and acted like she was having a great deal of pain that afternoon (08/20/24), which differed from her previous visits to Resident #13 while in the facility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the September 2024 MAR revealed Resident #13's pain level was rated a 7 on night shift on 09/01/24 (time not indicated). Further review of the September MAR revealed Resident #13 did not receive Acetaminophen for discomfort, nor was there any documented evidence non-pharmacological interventions were attempted. The September MAR further revealed Resident #13 did not receive Acetaminophen until 09/02/24 at 9:44 P.M. Interview on 09/03/24 with LPN #318 confirmed Resident #13 exhibited signs of pain during her shift (night shift on 09/01/24), including kicking, throwing herself around, and moaning when touched. LPN #318 further reported Resident #13's tube feed was leaking, she had a rash all over her and seemed to hurt whenever she was touched. During the interview, LPN #318 confirmed Resident #13 had no orders for pain medication, so she administered gave her lorazepam every four hours to decrease her restlessness. LPN #318 further stated that report was then given to the day shift nurse that Resident #13 needed an order for pain medication and a possible increase in her antianxiety medication. LPN #318 confirmed she did not administer an analgesic to Resident #13 when she displayed signs of pain during her shift from 09/01/24 to 09/02/24 because she had no orders. Review of the facility policy titled Pain Management and Assessment, dated 04/16/24, revealed the nurse was to provide a thorough pain assessment and treatment for relieve of pain. The policy further revealed indicators of pain may include facial grimacing during care, guarding or protecting part of the body, unexplained behaviors, moaning, change in breathing pattern, and muscle tenseness. This deficiency represents non-compliance investigated under Complaint Number OH00156274.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure pharmacy services provided for timely ordering, dispensing, acquiring, and administering of medications to meet the needs of each resident. This affected two residents (Resident #45 and Former Resident #58) out of four residents who were reviewed for medication administration. The facility census was 56. Findings include: 1. Review of the closed medical record for Former Resident (FR) #58 revealed an admitted [DATE] and a discharge date of [DATE]. Admission diagnoses included spondylolysis of the lumbar region, radiculopathy of the lumbar region, dizziness, anxiety, major depression, fibromyalgia, dermatophytosis, post-traumatic stress disorder (PTSD), dissociative and conversion disorder, disorders of the bladder, and postural orthostatic tachycardia syndrome. Review of the care plan dated 03/25/24 revealed FR #58 was at risk for impaired psycho-social well-being related to dissociative conversion disorder, PTSD, depression, and anxiety, and that she used antidepressants and antianxiety medications. Interventions included maintaining a daily routine, consulting with the pharmacy, counseling services, or medical provider as needed, providing a calm environment, and providing medications per physician's orders. Review of the physician orders revealed the following: An order dated 05/30/24 for desvenlafaxine extended release (ER) 24-hour 50 milligram (mg) (antidepressant) tablets, one tablet by mouth in the mornings for anxiety. An order dated 06/07/24 for Auvelity ER 4-105 mg oral tablets (antidepressant), take one tablet by mouth twice daily for depression. An order dated 07/01/24 for Estrace vaginal cream 0.1 mg per gram (hormone), insert two grams vaginally at bedtime every Monday, Wednesday, and Friday for low estrogen for three weeks. An order dated 07/03/24 for Estrace vaginal cream 0.1 mg per gram, insert one gram vaginally at bedtime for three weeks. An order dated 07/03/24 for fluconazole 150 mg tablet (antifungal), give one tablet by mouth every 72 hours for three administrations for a yeast infection. An order dated 07/02/24 for saccharomyces boulardii 250 mg capsules (probiotic), give one capsule by mouth two times a day for a probiotic. Review of the progress notes revealed the following electronic medication administration record (eMAR) notes: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/04/24: desvenlafaxine was in route from the pharmacy. 07/04/24: saccharomyces was in route from the pharmacy. 07/05/24: desvenlafaxine was in route from the pharmacy. 07/07/24: the pharmacy rejected the refill request for desvenlafaxine. 07/07/24: Estrace vaginal cream was unavailable and on order from the pharmacy. 07/09/24: Auvelity was not available and in route from the pharmacy. 07/10/24: Auvelity was listed as Medication on order. Review of the medication administration record (MAR) for July 2024 revealed the following medications were not administered on the following dates and times: Desvenlafaxine ER 24-hour 50 mg tablets, one tablet by mouth in the mornings for anxiety was not administered on 07/04/24, 07/05/24, or 07/07/24. Estrace vaginal cream 0.1 mg per gram, insert one gram vaginally at bedtime for three weeks was not administered on 07/01/24 or 07/07/24. Fluconazole 150 mg tablet, give one tablet by mouth every 72 hours for three administrations for a yeast infection was not administered on 07/09/24. Auvelity ER 4-105 mg oral tablets, take one tablet by mouth twice daily for depression was not administered on the evening of 07/09/24 or the morning of 07/10/24. Saccharomyces boulardii 250 mg capsules, give one capsule by mouth two times a day for a probiotic was not administered on 07/04/24. Interview on 08/21/24 with Licensed Practical Nurse (LPN) #304 confirmed FR #58 had voiced concern and was upset about missing doses of her antidepressant and antianxiety medications. LPN #304 further confirmed it was not uncommon to have residents miss a dose or two of medication due to the medication not arriving timely from the pharmacy. Review of the policy titled Medication Administration, dated 04/16/24, revealed medications were to be given as ordered and within the timeframe of one hour before or after the ordered administration time. 2. Review of the medical record for Resident #45 revealed an admitted [DATE] with diagnoses including compression of the brain, human immunodeficiency virus (HIV), anxiety disorder, primary hypertension, major depressive disorder, panic disorder, [NAME] Chiari Syndrome, prostatic hyperplasia, and third nerve palsy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366096	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem West Healthcare Center	2511 Bentley Drive Salem, OH 44460

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #45 had intact cognition and was independent with his personal care. Further review of the MDS revealed Resident #45 was on antidepressants and had a history of anxiety, depression, and PTSD. Review of the care plan dated 08/05/22 revealed Resident #45 was at risk for constipation and interventions included administration of medications per medical provider's orders. Further review of the care plan revealed Resident #45 had a behavior disturbance, experienced mood fluctuations, and was on antidepressants. The interventions included Resident #45 receiving medications as prescribed. Review of the physician orders revealed an order dated 07/16/24 for Abilify 10 mg (antipsychotic) by mouth daily at bedtime for depression. Further review of the orders revealed an order dated 06/16/22 for SM Fiber laxative 500 mg tablets, give two tablets by mouth every morning and at bedtime for constipation. Observation on 08/20/24 at 8:10 A.M. of medication administration revealed Resident #45 did not receive the ordered SM fiber laxative tablets as ordered. Interview at the time of the medication administration with LPN #334 confirmed the facility did not have the correct medication strength in stock so the dose was not able to be administered, and she would have to order the medication from the pharmacy. A review of the eMAR revealed documentation for the fiber laxative was coded as 9 (see progress noted). Review of the eMAR progress note dated 08/20/24 revealed the medication was order and the correct dose was needed. Further review of the August 2024 eMAR revealed the dose of Abilify, 10 mg daily for depression, was not administered on 08/17/24. Review of the eMAR progress note dated 08/17/24 revealed the Abilify was on order. Review of the policy titled Medication Administration, dated 04/16/24, revealed medications were to be given as ordered and within the timeframe of one hour before or after the ordered administration time. This deficiency represents non-compliance investigated under Complaint Number OH00155770.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, review of facility policy, and Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memorandum summary, reference number QSO-24-08-NH review the facility failed to ensure proper infection control procedures were implemented and followed for Resident #13. This affected one resident (#13) of three residents reviewed for incontinence care. The facility census was 56. Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including left femur fracture, Alzheimer's disease, metabolic encephalopathy, cognitive communication deficit, severe protein-calorie malnutrition, history of falling, acute respiratory failure, dysphagia, and attention to gastrostomy. Review of the Functional Abilities and Goals - Admission assessment completed 08/19/24 revealed Resident #13 was dependent on others for daily self-care. Review of the admission nurses progress note dated 08/17/24 revealed Resident #13 was incontinent of bowel and bladder and received nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube inserted through the skin into the stomach). Review of the care plan dated 08/17/24 revealed Resident #13 had the potential for altered nutrition and received enteral feedings. Interventions included providing tube feedings per orders. Further review of the care plan revealed no care planning related to enhanced barrier precautions (EBP). Review of the physician orders revealed there was no order for EBP. Observation on 08/20/24 from 2:10 P.M. to 2:25 P.M. revealed State tested Nurse Aide (STNA) #340 did not wear a gown to provide incontinence care to Resident #13. Further observation revealed Resident #13's PEG tube was exposed and Resident #13 kept pulling on the tube during the care being provided, with STNA #340 observed removing Resident #13's hand away from the PEG tube and manually stabilizing the PEG tube several times while completing the incontinence care. Interview on 08/20/24 at 2:30 P.M. with STNA #340 confirmed Resident #13 had a feeding tube. STNA #340 further confirmed she did not believe Resident #13 was in EBP but realized she should be, because of the presence of a feeding tube. STNA #340 confirmed a gown should be worn when performing close contact resident care when a resident had a PEG tube, and she did not don a gown to perform Resident #13's incontinence care. Interview on 08/20/24 3:27 P.M with Regional Director of Clinical Services (RDOCS) #335 confirmed EBP should be observed during the provision of incontinence care for residents with feeding tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Standard Precautions and Transmission based Precautions, dated 06/25/21, revealed no information regarding enhanced barrier precautions. Further review of the policy revealed standard and transmission-based precautions were implemented per CDC (Centers for Disease Control and Prevention) guidelines based on the resident's clinical condition. Review of the sign the facility posts on the doors of residents who were place in EBP revealed staff were to wear a gown and gloves for high contact resident care, including providing hygiene, changing briefs, or caring for a feeding tube. Review of the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memorandum summary, reference number QSO-24-08-NH, issued 03/20/24, revealed enhanced barrier precautions (EBP) in in long-term care facilities was effective on 04/01/24 to align with nationally accepted standards. The QSO memorandum further revealed EBP was to include residents indwelling medical devices, including central lines, urinary catheters, feeding tubes, and tracheostomies, during high contact care. This deficiency was an incidental finding identified during the complaint investigation.