

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER Salem West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 Bentley Drive Salem, OH 44460	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to honor a resident's documented code status. This affected one (Resident #73) of two residents reviewed for advance directives. Findings include: Review of Resident #73 's medical record revealed diagnoses including late onset Alzheimer 's disease, history of sudden cardiac arrest, hypertension, gastrostomy status, and cognitive communication deficit. Resident #73 had a signed Do Not Resuscitate Comfort Care - Arrest (DNR CC-A) order signed [DATE]. The form indicated a resident with a DNRCC-A would be treated as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions would cease and the DNR Comfort Care protocol would be implemented. The form instructed if a resident had a DNR providers would not perform cardiopulmonary resuscitation (CPR). A nursing note dated [DATE] at 2:38 P.M. indicated the nurse found Resident #73 to be cyanotic with a respiratory rate of three breaths per minute. Staff went to retrieve oxygen supplies while Licensed Practical Nurse (LPN) #115 grabbed the crash cart and another nurse called 911. CPR was initiated and one round of chest compressions and respirations were provided before Resident #73 's pulse stopped and all breaths ceased as confirmed by two nurses. Emergency medical technicians (EMT) arrived and confirmed. The hospice nurse also arrived and was updated on Resident #73 's death. During an interview on [DATE] at 10:49 A.M., the Director of Nursing (DON) confirmed staff had initiated CPR on Resident #73 on [DATE] as they were confused about the DNRCC-A order. The DON stated she educated nurses regarding a resident with a DNRCC-A should not have had CPR initiated. During an interview on [DATE] at 2:10 P.M., LPN #115 stated she nor Registered Nurse (RN) #150 understood what the A at the end of the DNRCC-A meant. CPR was initiated with one set of chest compressions and one set of breaths delivered before they stopped and verified they could not detect a pulse or respirations. It was during this assessment that EMTs arrived and scanned Resident #73 's hospital bracelet and determined he had a DNR order and confirmed Resident #73 was absent of breaths and heart beat. CPR was discontinued. This deficiency represents noncompliance investigated under Complaint Number 1374412 (OH00167460)</p>

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>Based on medical record review, interview and policy review the facility failed to ensure complaints of new onset pain were addressed in a timely manner. This affected one (Resident #34) of three residents reviewed for injuries. The facility census was 81. Actual harm occurred beginning on 06/11/25 when Resident #34, who had a diagnosis of dementia and required assistance with care, complained of pain in the right thigh and lower extremity and demonstrated increased agitation during therapy that was not comprehensively assessed or treated. On 06/12/25, Resident #34 was unable to stand and had ongoing complaints of pain affecting therapy participation and mobility. Facility staff did not notify the resident's medical provider until 06/26/25 at 11:40 P.M. when the resident again complained of right hip pain to the day shift nurse resulting in an x-ray order and it was determined the resident had a pathological fracture to the right femur. The resident was subsequently transferred to the hospital for evaluation and returned to the facility the same day with hospice services at the request of family. Findings include: Review of Resident #34's medical record revealed diagnoses including type two diabetes mellitus with diabetic polyneuropathy, bipolar disorder, pseudobulbar affect, contractures of bilateral knees, pain in bilateral knees, dementia with behavioral disturbance, need for assistance with personal care, schizophrenia, post-traumatic stress disorder, neurosyphilis, persistent mood disorder, anxiety disorder, emotional lability and psychosis. Review of physician orders revealed on 04/17/23, an order was written to monitor for pain every shift. Review of a Physical Therapy (PT) evaluation dated 05/14/25 indicated Resident #34 was referred to PT for recent decline in function and bilateral knee flexion contractures. Resident #34 presented with decreased lower extremity strength, bilateral knee flexion contractures, decreased sitting balance requiring increased assistance with bed mobility and Hoyer lift for transfers. There was no pain at rest. PT notes dated 05/27/25, 05/30/25, 06/02/25, 06/03/25, 06/04/25, 06/05/25, and 06/06/25 revealed therapy included range of motion exercises with weights and standing exercises with no documentation of complaints of pain. A PT note dated 06/09/25 indicated Resident #34 performed bilateral lower extremity exercises seated using three-pound weights. Resident #34 complained of pain when staff assisted with knee extension due to stretch on bilateral knee flexion contractures. A PT note dated 06/11/25 indicated bed mobility with moderate to maximum assistance to roll and to reposition for increased comfort as Resident #34 had complaints of increased pain in the right lower extremity. Resident #34 appeared to demonstrate increased agitation with the therapist when cued for increased assistance with bed mobility. Resident #34 declined to get out of bed to go to the therapy room to attempt stands with the turn stand. A PT note dated 06/12/25 indicated four attempts were made to get Resident #34 to rise to a standing position from a seated position. However, Resident #34 appeared to have difficulty clearing her bottom from the chair. Resident #34 was unable to complete any stands due to complaints of increased pain in her right upper thigh area. Nursing was notified. Resident #34 required prolonged seated rests to recover with complaints of increased fatigue and increased right upper thigh pain. Review of an Occupational Therapy (OT) note dated 06/12/25 indicated Resident #34 was unable to stand to work on balance goals and reported right leg pain. The note indicated nursing and the nurse practitioner were aware. Review of additional PT notes revealed on 06/16/25 Resident #34 complained of pain when her right lower extremity range of motion exercises were completed. The complaints were reported to nursing. A PT note dated 06/17/25 indicated Resident #34 complained of increased right lower extremity pain and screamed out it hurts when range of motion was provided. Standing was not attempted related to complaints of pain. Nursing was notified. A PT note dated 06/19/25 indicated Resident #34 complained of pain when exercising her lower extremities and was unable to complete full range requiring staff to assist with her exercises. Nursing was aware of leg pain. A PT progress note dated 06/23/25 indicated sit to stands attempts were made twice at the turn stand with max assist of two. However, Resident #34 was unable to clear her bottom from the chair. Resident #34 demonstrated complaints of increased RLE pain. Nursing was notified. Resident #34 had complaints of increased right lower extremity pain with movement. Nursing was notified of Resident #34's complaints of increased right leg pain. Prolonged rests were required in between sets. A PT note dated 06/24/25 indicated Resident #34 performed active assistive bilateral lower extremities were exercised seated using 2.5-pound weights to improve her strength and increase her ability to perform bed mobility and transfers upon discharge from therapy. Resident #34 continued to complain of pain when her right lower extremity was ranged and bilateral lower extremities were edematous. Nursing was aware. A PT note dated 06/26/25 indicated Resident #34's range was limited in</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure accuracy of medical records regarding bathing. This affected four (Residents #4, #5, #51 and #63) of six residents reviewed for provision of showers. Findings include: 1. Review of Resident #51's medical record revealed diagnoses including schizophrenia, bipolar disorder, depression, anxiety disorder, anxiety disorder, obsessive-compulsive disorder and dependent personality disorder. A nursing note dated 07/16/25 at 8:50 A.M. indicated Resident #51 was transferred out for a geriatric psych hospitalization. Review of nurse aide documentation in the electronic health record revealed Resident #51 was not available for showers/bathing on 07/23/25 and 07/27/25. However, shower sheet and body/skin inspection forms dated 07/23/25 and 07/27/25 indicated Resident #51 accepted showers and had skin assessments completed by nurses. Resident #51 was readmitted to the facility on [DATE]. During an interview on 08/21/25 at 11:00 A.M., it was addressed with the Director of Nursing that staff documented showers were given and skin assessments completed for Resident #51 while he was out at the hospital. No valid explanation was provided.2. Review of Resident #63's medical record revealed diagnoses including bipolar disorder, schizoaffective disorder, anxiety disorder, heart disease, congestive heart failure, and atrial fibrillation. Review of bathing records in the electronic health record revealed showers/bathing was not attempted due to medical condition or safety concerns on 07/23/25, 08/06/25 and 08/10/25. Review of shower sheets revealed inconsistencies with documentation in the electronic health record. Shower sheets on 07/23/25, 08/06/25 and 08/10/25 revealed Resident #63 refused showers instead of the shower not being attempted. There was a separate place in the electronic health record to indicate if showers were refused.On 08/18/25 at 2:03 P.M., Resident #63 stated he is told showers could not be offered at times due to staffing issues. Resident #63 denied showers were offered in accordance with the shower schedule.On 08/21/25 at 11:00 A.M. inconsistencies in documentation between the electronic health record and shower sheets were addressed with the DON who indicated she would need to educate nursing assistants on documentation.3. Review of Resident #4's medical record revealed diagnoses including chronic obstructive pulmonary disease, conduct disorder, generalized muscle weakness, contractures of multiple sites, and schizophrenia. A care plan initiated 09/27/22 indicated Resident #4 had activity of daily living (ADL) self-care performance deficit. Resident #4 required a hooyer for all transfers with two assists. Resident #4 was totally dependent on staff for all ADLs including bathing. Aide documentation in the electronic health record revealed between 07/20/25 and 08/17/25 staff documented showers were not attempted due to environmental limitations on 07/27/25 and 08/17/25. A shower was not attempted on 07/20/25 due to medical condition or safety concerns. However, a shower sheet and body/skin inspection form was provided for 07/27/25 indicating a shower was accepted.On 08/21/25 at 11:00 A.M. inconsistencies in documentation between the electronic health record and shower sheets were addressed with the DON who indicated she would need to educate nursing assistants on documentation.4. Review of Resident #5's medical record revealed diagnoses including Parkinson's disease, dementia, psychosis, type two diabetes mellitus, anxiety disorder, and post-traumatic stress disorder. A care plan regarding ADL self care performance deficit initiated 06/19/23 indicated Resident #5 was totally dependent on staff for bathing. Review of bathing records between 07/24/25 and 08/17/25 revealed documentation in the electronic health record indicated bathing was not attempted due to environmental limitations on 07/27/25 and 08/17/25. However, shower sheets were provided indicated a shower was accepted on 07/27/25.On 08/21/25 at 11:00 A.M. inconsistencies in documentation between the electronic health record and shower sheets were addressed with the DON who indicated she would need to educate nursing assistants on documentation.This deficiency is an incidental finding discovered during the complaint investigation.</p>		