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	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem West Healthcare Center	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)
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. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of staff time punches, interviews, and review of facility policy, the facility failed to ensure Resident #28 was free from verbal abuse by a staff member. This affected one resident (Resident #28) of three residents reviewed for abuse. Findings Include:Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, diabetes, hypertension, diverticulitis, adult failure to thrive, schizoaffective disorder, anxiety disorder, and scoliosis. Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #28 had moderately impaired cognition.Review of the Nursing Notes from 01/01/25 through 11/15/25 revealed no documentation of any incident of verbal abuse.Review of the hospice incident report for Resident #28 revealed on 11/10/25 at 11:14 A.M. Hospice Aide #400 called the hospice supervisor and reported the facility aide [CNA #100] was verbally loud with a resident after she turned on her call light too often. The facility aide told the resident she would take her call light away. The facility ' s nurse [indicating the nurse aide, CNA #203] asked the hospice aide to report the incident to the Assistant Director of Nursing due to her witnessing the event. The hospice aide spoke to the facility Administrator about the incident.Review of the typed signed statement from the Administrator dated 11/10/25 revealed she had spoken with the Hospice Aide [#400] concerning Resident #28 and Certified Nursing Assistant (CNA) #100. The hospice aide stated she was encouraged to say something to the Administrator. The hospice aide stated she did not have anything specific other than CNA #100 spoke more loudly than other staff members. The hospice aide stated that CNA #100 ' s voice carried and some of the other staff members thought she spoke loudly. There was no yelling directed at any specific person. A Self-Reported Incident (SRI) was not implemented because no SRI reportable was reported.Review of the time punches for CNA #100 revealed she worked on 11/10/25 from 6:05 A.M. through 6:16 P.M. and she continued working at the facility on 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/28/25, 11/30/25, 12/01/25, and 12/02/25.On 12/03/25 at 6:20 P.M. an interview with CNA #203 revealed on 11/10/25 the Hospice Aide [#400] heard CNA #100 yelling at Resident #28 when she came to visit her. She stated she told her to report it to the Administrator and Director of Nursing (DON) and she did. She stated they had a meeting with hospice regarding the incident, but nothing was done. She [CNA #203] also notified the Administrator herself, about the interaction the hospice aide observed with Resident #28 and CNA #100, when it happened a month ago.On 12/04/25 at 9:11 A.M. an interview with Hospice Director #410 revealed Hospice Aide #400 had gone to the facility Administrator the day of the incident and told her about it. She stated that since then the Hospice Social Worker was made aware and was in touch with the facility, and an occurrence was entered into their records on that day regarding what was heard. She stated Hospice Aide #400 had told her what had happen because she was upset about what had occurred. She stated the hospice aide had reached out to her and stated she was visiting with a resident and requested her nails be cleaned that day, so Hospice Aide #400 had left the room to find an aide to get an orange stick to clean under her fingernails. She stated the aide was on the phone, so it took her a little more time to get back to Resident #28 and the resident had turned her call light on again. She stated another aide, CNA #100 had entered the resident ' s room and Hospice Aide #400 was following her into the room. She stated Hospice Aide #400 heard CNA #100 yelling at Resident #28 telling her they were not doing this today, you need to be patient, and told her if she continued to turn her call light on she would take the call light from her. She stated Hospice Aide #400 stated CNA #100 was speaking aggressively to the resident. She stated at that point Hospice Aide #400 reported it to the Administrator and then called the office to notify them of the incident. She stated it was on 11/10/25. On 12/04/25 at 9:30 A.M. an interview with Hospice Aide #400 revealed on 11/10/25 she was at the facility to see Resident #28, and she asked her to go down the hall and find the aide because she was supposed to get her an orange stick to clean her nails. She stated she did that, but when she went out to find the aide, she was on phone so she was waiting for her to get off the phone. She stated while she was waiting for the aide to get off the phone, Resident #28 had turned her call light back on and CNA #100 went down the hall to answer it. She stated she had obtained the orange stick and was following CNA #100 into the room and she said to Resident #28 that she was not going to be doing this today, she was not going to be turning her call light on every five minutes, she needed to be patient, she was being impatient, and if she was going to do this she, was going to take the call light from her. She stated she did not like how CNA #100

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of the medical record, review of the Self-Reported Incident (SRI) Investigation, interview, and review of the facility policy, the facility failed to ensure submission of SRI investigations were complete to include suspected perpetrators (SP) for tracking purposes, to ensure the facility and the State agency had the ability to identify potentially similar occurrences and allegations related to the same staff member. This affected two residents (#21 and #46) out of three reviewed for abuse and had the potential to affect all 20 residents (#4, #13, #14, #15, #20, #21, #27, #28, #34, #36, #39, #42, #43, #45, #46, #58, #59, #61, #62, and #63) who resided on the secure unit. Findings Include:1. Review of SRI 265131 revealed Licensed Practical Nurse (LPN) #122 stated Certified Nursing Assistant (CNA) #100 was attempting to have Resident #46 sit down so she could get her wheelchair and assist her to the bathroom. CNA #100 asked the resident several times and the resident started to yell at CNA #100 in Spanish. The CNA #100 got loud with Resident #46 so LPN #122 went to help and got Resident #46 to sit in the chair and calm down.Further review of SRI #265131 revealed an SP was not identified in the SRI section for tracking SP's even though the facility was aware of the staff member involved due to being named in the investigation, which was CNA #100. The facility was notified on 09/18/25 by the State agency to add the SP and they had not completed the action. Review of the police report dated 09/13/25 revealed the Officer responded to the facility for a complaint for an employee, CNA #100, who was involved in three sperate incidents at the facility. The employee was placed on administrative suspension until the investigation was concluded.Interview of 12/01/25 at 2:30 P.M. with Certified Nursing Assistant (CNA) #104 revealed CNA #100 was always getting into the resident's face and screaming at them. She stated they had reported her three times with nothing being done so she quit. She stated she was also there when she was in Resident #46's face yelling at her. She stated Resident #46 had dementia and only spoke Spanish and CNA #100 was yelling at her to speak English because she could not understand her when she spoke Spanish. 2. Review of SRI 265185 dated 09/13/25 revealed during an investigation on another SRI, it was reported by CNA #200 on 09/10/15 that she witnessed CNA #100 start yelling loudly and raised her arm at Resident #21, but did not hit her. It noted that Resident #21 had run over CNA #100's foot with the wheelchair.Further review of the SRI #265185 revealed an SP was not identified in the SRI section for tracking SP's, even though the facility was aware of the staff member involved due to being named in the investigation, which was CNA #100.Review of the police report dated 09/13/25 revealed the Officer responded to the facility for a complaint for an employee, CNA #100, who was involved in three sperate incidents at the facility. The employee was placed on administrative suspension until the investigation was concluded.On 12/03/25 at 11:45 A.M. an interview with the Director of Nursing verified CNA #100 was the SP, however she was not listed as an SP on SRI 265131 and 265185.Further review of facility SRIs revealed CNA #100 was involved in four other SRIs (#265184, #268248, #268392, and #268406) where she was named in the SRI as an SP.Review of the undated facility policy titled, Ohio Abuse, Neglect and Misappropriation, revealed it was the policy of the facility to provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents. It was the intent of the facility to prevent the abuse, mistreatment or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct care staff to manage any concerns or allegations of abuse, neglect or misappropriation. Accurate and timely reporting of incidents, both alleged and substantiated, would be sent to officials in accordance with state law. Each occurrence of a resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation would be identified and reported to the supervisor and investigated timely. The supervisor or designee would notify the Director of Nursing or Executive Director of the incident or allegation immediately and required notification of agencies, physician, and representative would be completed. The Executive Director would direct the investigation.This deficiency represents non-compliance investigated under Complaint Number 2617636.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of staff time punches, review of facility self reported incidents (SRI), interviews, and review of facility policy, the facility failed to notify the State agency of an allegation of verbal abuse by a staff member. This affected one resident (Resident #28) of three residents reviewed for abuse. Findings Include:Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, diabetes, hypertension, diverticulitis, adult failure to thrive, schizoaffective disorder, anxiety disorder, and scoliosis.Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #28 had moderately impaired cognition.Review of the Nursing Notes from 01/01/25 through 11/15/25 revealed no documentation of any incident of verbal abuse.Review of the hospice incident report for Resident #28 revealed on 11/10/25 at 11:14 A.M. Hospice Aide #400 called the hospice supervisor and reported the facility aide [CNA #100] was verbally loud with a resident after she turned on her call light too often. The facility aide told the resident she would take her call light away. The facility ' s nurse [indicating the nurse aide, CNA #203] asked the hospice aide to report the incident to the Assistant Director of Nursing due to her witnessing the event. The hospice aide spoke to the facility Administrator about the incident.Review of the typed signed statement from the Administrator dated 11/10/25 revealed she had spoken with the Hospice Aide [#400] concerning Resident #28 and Certified Nursing Assistant (CNA) #100. The hospice aide stated she was encouraged to say something to the Administrator. The hospice aide stated she did not have anything specific other than CNA #100 spoke more loudly than other staff members. The hospice aide stated that CNA #100 ' s voice carried and some of the other staff members thought she spoke loudly. There was no yelling directed at any specific person. A Self-Reported Incident (SRI) was not implemented because no SRI reportable was reported.Review of the State agency notification system for abuse allegations revealed no SRI was submitted related to the 11/10/25 allegation of verbal abuse by CNA #100 towards Resident #28.Review of the time punches for CNA #100 revealed she worked on 11/10/25 from 6:05 A.M. through 6:16 P.M. and she continued working at the facility on 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/28/25, 11/30/25, 12/01/25, and 12/02/25.On 12/03/25 at 6:20 P.M. an interview with CNA #203 revealed on 11/10/25 the Hospice Aide [#400] heard CNA #100 yelling at Resident #28 when she came to visit her. She stated she told her to report it to the Administrator and Director of Nursing (DON) and she did. She stated they had a meeting with hospice regarding the incident, but nothing was done. She [CNA #203] also notified the Administrator herself, about the interaction the hospice aide observed with Resident #28 and CNA #100, when it happened a month ago.On 12/04/25 at 9:11 A.M. an interview with Hospice Director #410 revealed Hospice Aide #400 had gone to the facility Administrator the day of the incident and told her about it. She stated that since then the Hospice Social Worker was made aware and was in touch with the facility, and an occurrence was entered into their records on that day regarding what was heard. She stated Hospice Aide #400 had told her what had happen because she was upset about what had occurred. She stated the hospice aide had reached out to her and stated she was visiting with a resident and requested her nails be cleaned that day, so Hospice Aide #400 had left the room to find an aide to get an orange stick to clean under her fingernails. She stated the aide was on the phone, so it took her a little more time to get back to Resident #28 and the resident had turned her call light on again. She stated another aide, CNA #100 had entered the resident ' s room and Hospice Aide #400 was following her into the room. She stated Hospice Aide #400 heard CNA #100 yelling at Resident #28 telling her they were not doing this today, you need to be patient, and told her if she continued to turn her call light on she would take the call light from her. She stated Hospice Aide #400 stated CNA #100 was speaking aggressively to the resident. She stated at that point Hospice Aide #400 reported it to the Administrator and then called the office to notify them of the incident. She stated it was on 11/10/25. On 12/04/25 at 9:30 A.M. an interview with Hospice Aide #400 revealed on 11/10/25 she was at the facility to see Resident #28, and she asked her to go down the hall and find the aide because she was supposed to get her an orange stick to clean her nails. She stated she did that, but when she went out to find the aide, she was on phone so she was waiting for her to get off the phone. She stated while she was waiting for the aide to get off the phone, Resident #28 had turned her call light back on and CNA #100 went down the hall to answer it. She stated she had obtained the orange stick and was following CNA #100 into the room and she said to Resident #28 that she was not going to be doing this today, she

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of staff time punches, review of facility self reported incidents (SRI), interviews, and review of facility policy, the facility failed to thoroughly investigate and take immediate action to protect a resident after an allegation of verbal abuse by a staff member. This affected one resident (Resident #28) of three residents reviewed for abuse and had the potential to affect all 20 residents who resided on the secure unit.Findings Include:Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, diabetes, hypertension, diverticulitis, adult failure to thrive, schizoaffective disorder, anxiety disorder, and scoliosis.Review of the Significant Change Minimum Data Set assessment dated [DATE] revealed Resident #28 had moderately impaired cognition.Review of the Nursing Notes from 01/01/25 through 11/15/25 revealed no documentation of any incident of verbal abuse.Review of the hospice incident report for Resident #28 revealed on 11/10/25 at 11:14 A.M. Hospice Aide #400 called the hospice supervisor and reported the facility aide [CNA #100] was verbally loud with a resident after she turned on her call light too often. The facility aide told the resident she would take her call light away. The facility ' s nurse [indicating the nurse aide, CNA #203] asked the hospice aide to report the incident to the Assistant Director of Nursing due to her witnessing the event. 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M. and she continued working at the facility on 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/28/25, 11/30/25, 12/01/25, and 12/02/25.On 12/03/25 at 6:20 P. M. an interview with CNA #203 revealed on 11/10/25 the Hospice Aide [#400] heard CNA #100 yelling at Resident #28 when she came to visit her. She stated she told her to report it to the Administrator and Director of Nursing (DON) and she did. She stated they had a meeting with hospice regarding the incident, but nothing was done. She [CNA #203] also notified the Administrator herself, about the interaction the hospice aide observed with Resident #28 and CNA #100, when it happened a month ago.On 12/04/25 at 9:11 A.M. an interview with Hospice Director #410 revealed Hospice Aide #400 had gone to the facility Administrator the day of the incident and told her about it. 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She stated Hospice Aide #400 heard CNA #100 yelling at Resident #28 telling her they were not doing this today, you need to be patient, and told her if she continued to turn her call light on she would take the call light from her. She stated Hospice Aide #400 stated CNA #100 was speaking aggressively to the resident. She stated at that point Hospice Aide #400 reported it to the Administrator and then called the office to notify them of the incident. She stated it was on 11/10/25. On 12/04/25 at 9:30 A.M. an interview with Hospice Aide #400 revealed on 11/10/25 she was at the facility to see Resident #28, and she asked her to go down the hall and find the aide because she was supposed to get her an orange stick to clean her nails. She stated she did that, but when she went out to find the aide, she was on phone so she was waiting for her to get off the phone. She stated while she was waiting for the aide to get off the phone, Resident #28 had turned her call light back on and CNA #100 went down the hall to answer it. She stated she had obtained the orange stick and was following CNA #100 into the room and she said to Resident #28 that she was not going to be doing this today, she was not going to be turning her call

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, review of the facility floor plan, and interview, the facility failed to ensure a fire pull station was visible and accessible in the event of an emergency. This had the potential to affect all 70 residents in the facility.Findings Include:Review of the facility floor plan revealed they had 14 fire pull stations in the facility. On 09/28/25 at 4:45 P.M. an interview with Resident #22 revealed he was concerned about the shelving blocking the fire pull station behind the nurse ' s station.An observation 11/03/25 at 10:45 A.M. revealed the wheeled cart of resident charts was stored/parked in front of the fire pull station. An interview with Licensed Practical Nurse #215 at this time verified the fire pull station behind the nurse ' s station was not accessible due to being obscured by the rack of resident ' s charts. This deficiency represents non-compliance investigated under Complaint Number 2606357.