

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 04/30/2026
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, review of physician orders, policy review, and interview, the facility failed to ensure medications were administered in accordance with physician orders. This resulted in three medication errors out of 26 opportunities resulting in an 11.1% medication error rate. This affected two (Residents #5 and #36) of five residents observed for medication administration. 1. On 04/28/26 at 8:42 A.M., Licensed Practical Nurse (LPN) #110 was observed administering medication to Resident #36. While preparing Resident #36's medication, LPN #110 indicated Resident #36 did not have some medications in the medication cart. The medications not available included nifedipine (calcium channel blocker). LPN #110 checked the pyxis medication dispensing machine and indicated nifedipine was not available. LPN #110 stated she would have to contact pharmacy to let them know the nifedipine was not available for administration. Resident #36 was offered the remainder of the medication. Upon returning to the medication cart, LPN #110 documented the nifedipine was not available for administration and she would contact the pharmacy for refills. Review of Resident #36's physician orders revealed an order dated 02/13/25 for nifedipine Extended Release 60 milligrams (mg) every day. 2. On 04/28/26 at 9:32 A.M., Registered Nurse (RN) #130 was observed administering medication to Resident #5. Included in the medications that were administered was one tablet of furosemide (diuretic) 40 mg and one tablet of magnesium oxide 400 mg. Review of Resident #5's orders revealed there were no current orders for furosemide. (The most recent order for furosemide was discontinued 12/19/24). Resident #5's orders indicated instead of magnesium oxide 400 mg, Resident #5 had an order for two SlowMag Muscle/Heart delayed release 71.5 -119 mg (Magnesium chloride-calcium carbonate) tablets to be administered twice a day. On 04/28/26 at 10:08 A.M., RN #130 indicated he did not individually check the medications listed on the medication packets, each of which contained multiple medications. RN #130 stated he just scanned the bar codes on the packets then looked for any medications which was not indicated as being present in the packets. RN #130 stated he administered magnesium oxide because slow mag was not available and verified the two were not the same. On 04/28/26 at 12:25 P.M., Corporate Registered Nurse #100 stated when medication packets were scanned if a resident had a medication that had been discontinued, a warning was supposed to come up on the screen. She would have to call pharmacy and inform them that had not occurred with the administration of the furosemide. Review of the facility's Medication Administration policy (undated) revealed instructions to administer medication only as prescribed by the provider. Observe the five rights of medication administration which included ensuring the right medication and right dose was administered. The medication label was to be read three times prior to administering the medication and included comparing the label to the Medication Administration Record. This deficiency represents non-compliance investigated under Complaint Number 2978871.</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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