

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/23/2026
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, medical record review, policy review, and interview, the facility failed to ensure a nurse implemented professional standards of practice when he failed to ensure a medication's expiration/use by date and administered the medication to a resident. This affected one resident (#8) of six residents observed during medication administration. Findings include: On 07/21/26 at 11:34 A.M., Registered Nurse (RN) #100 was observed preparing three units of insulin lispro (rapid acting insulin) 100 units per milliliter (u/ml) for administration to Resident #8. The insulin box and vial had an open date of 06/02/26. After RN #100 locked the cart and started to enter Resident #8's room with the syringe and alcohol swab, RN #100 was stopped by the surveyor. When asked when the insulin vial had been opened, RN #100 indicated that was a good question as he had not checked the information prior to preparing the insulin. RN #100 returned to the cart and verified the date marked on the vial and box was 06/02. RN #100 stated the insulin should not be used past 28 days of it being opened. RN #100 retrieved a new vial of insulin lispro from the medication room for administration. On 07/22/26 at 4:10 P.M., RN #105 verified it was a nurse's responsibility to ensure medications were not expired prior to administration. Review of the facility's Storage of Medications policy (effective September 2025) revealed certain medications or package types, such as multiple dose injectable vials, once opened, required both an opened date and an expiration date, which may be shorter than the manufacturer's expiration date to insure medication purity and potency. Drugs dispensed in the manufacturer's original container would carry the manufacturer's expiration date. Once opened, these would be good to use until the manufacturer's expiration date was reached unless the medication was in a multi-dose injectable vial, an ophthalmic medication or an item for which the manufacturer had specified a usable life after opening. When the original seal of a manufacturer's container or vial was initially broken, the nurse should label the medication with the date opened and the new date of expiration. The expiration date of the vial or container would be 30 days unless the manufacturer recommended another date or regulations/guidelines required different dates. No expired medication was to be administered to a resident. All expired medications were to be removed from the active supply and destroyed in accordance with facility policy, regardless of the amount remaining. Review of the facility's Medication Storage Best Practice Guideline (not dated) revealed all insulin vials/pens should be dated when opened once removed from the medication refrigerator. Place a Beyond-Use Date label on the bag and count forward the manufacturer's recommended days and indicate it on the label. The form indicated open vials of insulin lispro could be stored at room temperature for four weeks. Review of manufacturer information revealed once insulin lispro was opened, it should be thrown away after 28 days even if it still contained insulin. This deficiency represents non-compliance investigated under Complaint Number 3052754.		

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, review of physician orders, policy review and interview, the facility failed to implement physician orders related to monitoring a feeding tube for placement and flushing the tube. This affected one resident (#23) of six residents observed during medication administration. Findings include: Review of Resident #23's physician orders revealed orders including buspar (anti-anxiety medication) 10 milligrams (mg) three times a day (start date of 07/10/26), prednisone (corticosteroid) 10 mg every day (start date 04/07/26), tizanidine (skeletal muscle relaxant) 4 mg three times a day, Jevity 1.5 five times a day (start date 12/11/25), polyethylene glycol (laxative) 17 grams every day (start date 05/07/26), flush enteral tube with at least 15 milliliters (mls) of water before and after each medication pass with 15 ml of flush given in between each medication and flush with 15 ml of water before and after tube feeding (start date 09/09/25), and verify enteral tube placement before feedings, flushes and medication passes by checking for gastric contents. Notify the physician if gastric contents were not visualized (start date 09/09/25). On 07/21/26 between 8:00 A.M. and 8:22 A.M., Licensed Practical Nurse (LPN) #110 was observed preparing Resident #23's above medications and nutritional feeding. LPN #110 reviewed orders and crushed the buspar, prednisone and tizanidine together in a medication cup. On 07/21/26 at 8:38 A.M., LPN #110 was observed initiating the medication administration. Between 5-10 ml of water had been added to the three crushed medications. LPN #110 checked for gastric contents and none was noted in the tube. LPN #110 proceeded to empty the contents of the medication cup (buspar, prednisone and tizanidine) into the feeding tube without flushing the tube. The medications would not go into the tube. The medications were poured back into the medication cup and LPN #110 stated she would have to get Registered Nurse (RN) #120 to unclog the tube. On 07/21/26 at 8:47 A.M., LPN #110 verified there had been no gastric contents observed when she was attempting to verify placement of the tube. At 8:50 A.M., RN #120 informed LPN #110 that Resident #23's feeding tube had been flushed and it was operating appropriately. On 07/21/26 between 9:00 A.M. and 9:13 A.M., LPN #110 was observed pouring the three crushed medications with water into the feeding tube followed by approximately half of the polyethylene glycol solution that had been mixed with water. LPN #110 proceeded to administer the Jevity 1.5 then finished providing the remainder of the polyethylene glycol. There was no water flush after the medications were administered. On 07/21/26 at 9:15 A.M., LPN #110 verified although she had not been able to obtain gastric contents when checked, she proceeded to administer medications and nutritional formula without notifying the physician in accordance with orders. LPN #110 also verified she had not flushed the tube prior to attempting the initial medication administration and had not flushed the tube after medication administration. Review of the facility's Medication Administered by Enteral Tube policy (effective date of 04/06/26) revealed instructions to validate tube placement by aspirating 15-30 ml of stomach contents using a 60 ml catheter-tipped syringe. Replace stomach contents once placement was verified. If placement could not be verified, do not administer medications and contact the physician. Remove the plunger from the syringe and connect the syringe to clamped tubing. Place approximately 15 ml of tepid water or as directed in the syringe, unclamp the tube and flush tubing using gravity flow. Flush with a minimum of 15 ml of tepid water or as directed between each medication. After final medications, flush with 60 ml of tepid water or as directed by physician order. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 3052754.		

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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. Based on observation, review of physician orders, and interview, the facility failed to ensure medications were available for administration as ordered. This affected two residents (#23 and #26) of six residents observed for medication administration. The census was 67. Findings include: 1. During observation of medication preparation and administration for Resident #23 by Licensed Practical Nurse (LPN) #110 revealed when preparation began between 8:00 A.M. and 8:22 A.M., no carafate (anti-ulcer medication) was available for administration. As lactulose (laxative) was prepared for administration less than 30 milliliters (ml) was available. The lactulose was mixed into a cup with miralax and water. When LPN #110 entered Resident #23's room to administer medication, he had left his room. LPN #110 disposed of the miralax and lactulose mixture. Resident #23 returned to his room at 8:24 A.M. LPN #110 prepared the miralax for administration but was unable to locate any lactulose. LPN #110 stated she would have to call pharmacy to see if they could deliver the lactulose. The Director of Nursing (DON) was passing and was informed by LPN #110 that she did not have lactulose or carafate available for administration. The DON offered to call the pharmacy. Review of Resident #23's medical record revealed diagnoses including gastro-esophageal reflux disease. Review of the July 2026 Medication Administration Record (MAR) and associated notes revealed orders to start lactulose 10 grams per 15 milliliters (gm/ml) on 05/08/26 with instructions to give 30 ml every day for constipation. A nursing notation dated 07/21/26 at 8:53 A.M. indicated pharmacy was to deliver the lactulose. There was no indication if the lactulose was going to be delivered with the regular delivery or a special delivery and there were no further notes of the lactulose being administered after it was received on 07/21/26. Review of the July 2026 MAR revealed an order for sucralfate 1 gm/10 ml with instructions to give 10 ml via the feeding tube before meals (start date of 04/06/26). An associated note indicated the sucralfate was not given but was supposed to be delivered by pharmacy that day. The order for the sucralfate was discontinued on 07/21/26 and a new order was written for sucralfate 1 gram to be administered every morning and at bedtime with the first dose administered documented at bedtime on 07/21/26. 2. On 07/21/26 at 9:30 A.M., LPN #110 was observed administering medication to Resident #26. LPN #110 reported she had no lactulose to administer in accordance with physician orders. Review of Resident #26's physician orders revealed an order to administer 30 ml of lactulose oral solution 10 gm/15 ml every morning and at bedtime for constipation starting on 03/25/26. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 3052754.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, medical record review, policy review, and interview, the facility failed to ensure residents were free from significant medication errors in regard to expired insulin being used for administration. This affected one resident (#8) of six residents observed during medication administration. Findings include: On 07/21/26 at 11:34 A.M., Registered Nurse (RN) #100 was observed preparing three units of insulin lispro (rapid acting insulin) 100 units per milliliter (u/ml) for administration to Resident #8. The insulin box and vial had an open date of 06/02/26. After RN #100 locked the cart and started to enter Resident #8's room with the syringe and alcohol swab, RN #100 was stopped by the surveyor. When asked when the insulin vial had been opened, RN #100 indicated that was a good question. RN #100 returned to the cart and verified the date marked on the vial and box was 06/02. RN #100 stated the insulin should not be used past 28 days of it being opened. RN #100 retrieved a new vial of insulin lispro from the medication room for administration. Review of Resident #8's medical record revealed diagnoses included morbid obesity, type two diabetes mellitus with diabetic polyneuropathy (type of nerve damage that occurs as a complication of diabetes), type two diabetes mellitus with diabetic peripheral angiopathy (blood vessel disease caused by high glucose levels which limits blood flow to the legs and feet), and diabetic nephropathies (progressive kidney disease). Review of Resident #8's physician orders revealed orders to start Insulin lispro 100 u/ml via sliding scale for blood glucose levels between 151 and 400 before meals and at bedtime. Review of Resident #8's July 2026 Medication Administration Record (MAR) indicated insulin lispro was provided via sliding scale coverage at bedtime 14 days between 07/01/26 and 07/20/26. Insulin lispro was provided via sliding scale coverage before meals 32 times between 07/01/26 and lunchtime on 07/21/26. Review of the facility's Storage of Medications policy (effective September 2025) revealed certain medications or package types, such as multiple dose injectable vials, once opened, required both an opened date and an expiration date, which may be shorter than the manufacturer's expiration date to insure medication purity and potency. Drugs dispensed in the manufacturer's original container would carry the manufacturer's expiration date. Once opened, these would be good to use until the manufacturer's expiration date was reached unless the medication was in a multi-dose injectable vial, an ophthalmic medication or an item for which the manufacturer had specified a usable life after opening. When the original seal of a manufacturer's container or vial was initially broken, the nurse should label the medication with the date opened and the new date of expiration. The expiration date of the vial or container would be 30 days unless the manufacturer recommended another date or regulations/guidelines required different dates. No expired medication was to be administered to a resident. All expired medications were to be removed from the active supply and destroyed in accordance with facility policy, regardless of the amount remaining. Review of the facility's Medication Storage Best Practice Guideline (not dated) revealed all insulin vials/pens should be dated when opened once removed from the medication refrigerator. Place a Beyond-Use Date label on the bag and count forward the manufacturer's recommended days and indicate it on the label. The form indicated open vials of insulin lispro could be stored at room temperature for four weeks. Review of manufacturer information revealed once insulin lispro was opened, it should be thrown away after 28 days even if it still contained insulin. This deficiency represents non-compliance investigated under Complaint Number 3052754.		