

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

Printed: 07/31/2025
Form Approved OMB
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 04/29/2025
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, observation, interview, and review of facility policy, the facility failed to provide a dignified dining experience for all residents. This affected one resident (#23) of five residents reviewed for food/nutrition. The facility census was 64. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including muscle weakness, contracture of muscle of multiple sites, and transient ischemic attack. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/07/25, revealed Resident #23 had severely impaired cognition for daily decision making and was dependent on staff for eating assistance. Review of the activities of daily living (ADLs) care plan, revised 11/20/24, revealed Resident #23 had an ADL self-care performance deficit related to chronic obstructive pulmonary disease, contractures, weakness, cognitive deficit, and functional deficit. Interventions included total dependence on staff for eating with the helper doing all the effort and the resident doing none of the effort. An observation on 04/17/25 from 8:13 A.M. to 8:30 A.M. in the dining room revealed Certified Nursing Assistant (CNA) #550 stood over Resident #23 as CNA #550 fed Resident #23. CNA #550 remained standing while feeding throughout the observation. An interview was conducted on 04/17/25 at 8:23 A.M. with CNA #550 who verified she was standing while feeding Resident #23. CNA #550 stated she always stood while providing feeding assistance to residents. Review of the facility policy titled Routine Resident Care, not dated, revealed care necessary for quality of life promoting dignity and independence would be provided by facility staff, including assisting with eating and hydration. This deficiency represents non-compliance investigated under Complaint Numbers OH00164146 and OH00162382.		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, record review, interview and review of facility policy, the facility failed to ensure call lights were within reach for Resident #50, #56 and #60, and failed to ensure Resident #20 was reasonably accommodated to meet his shower preference. This affected four residents (#20, #50, #56 and #60) of 22 residents reviewed for accomodation of needs/preferences. The facility census was 64. Findings include: 1. Observation on 04/14/25 at 9:17 A.M. revealed Resident #56 was resting in bed with his call light draped on a light fixture above his bed not within reach. The observation was confirmed by Licensed Practical Nurse (LPN) #515 who stated call lights should be within reach of residents at all times. Resident #56 was not interviewable. Observation on 04/21/25 at 8:25 A.M. revealed Resident #56 was sleeping in bed and his call light was on the floor behind his bed. The observation was confirmed with LPN #503 and she stated call lights should be within reach of residents at all times. 2. Observation on 04/23/25 at 10:36 A.M. revealed Resident #60 was asleep in bed and the call light was pinned to a privacy curtain that was not within reach of Resident #60. Certified Nursing Assistant (CNA) #574 was present at the time of the observation and confirmed the call light was not within the resident's reach and should be in reach at all times. Review of resident council minutes for November 2024 revealed concerns related to call lights being left in inappropriate locations. 46195 3. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), type two diabetes, unspecified dementia, schizoaffective disorder, anxiety disorder, depression, bipolar disorder, and suicidal ideations. Review of Resident #50's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/03/25, revealed the resident was moderately impaired cognitively; exhibited behavioral symptoms not directed toward others one to three days of the assessment reference period; wandered one to three days of the assessment reference period, required supervision or touch for mobility which included walking up to 150 feet. Further review of Resident #50's medical record revealed a care plan with an initiation date of 01/24/25 which indicated the resident required a secure unit related to behaviors, elopement risk, and poor cognition. Interventions included the resident may have a long call cord light. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/14/25 at 10:41 A.M. revealed Resident #50 was lying on her bed with no call light within reach of the resident. The call light cord was observed to be approximately two feet long and was hanging from the call system located in the middle of the right-hand wall of the room. Interview at the time of the observation with Resident #50 revealed she was unable to reach the call cord when she was lying on the bed. Interview on 04/14/25 at 10:55 A.M. with LPN #515 confirmed the call light was short and was not in reach of Resident #50. Interview on 04/15/25 at 10:16 A.M. with the Ombudsman revealed there was an open case regarding concerns with the short emergency call cords on the secure unit and the residents not being able to reach them. Interview on 04/15/25 at 1:39 P.M. with Director of Plant Maintenance (DPM) #516 stated the secured unit was recently opened and the rooms on the unit would have a long or short call cord depending on their diagnosis. Observation during an environmental tour on 04/15/25 with DPM #516 from 2:02 P.M. to 4:24 P.M. revealed there were both long and short emergency call cords in the residents rooms on the secure unit. Review of the undated facility policy titled Resident Rights revealed call light would be within reach of the resident. Review of the undated facility policy titled Secured (Locked) Unit 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. The unit would be adequately staffed to address the needs of the residents; would provide a homelike environment to the extent possible; would have secured areas for medications, cleaning supplies, treatment, and other products that might pose a potential hazard if inadvertently entered; would be quiet and away from unnecessary noise and interruptions; and would have secure areas to wander within the unit. There was nothing documented in the policy indicating the unit would have short and long emergency call cords. 4. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included morbid (severe) obesity, bipolar disorder, schizoaffective disorder, type two diabetes, and anxiety disorder. Review of Resident #20's quarterly MDS 3.0 assessment, dated 03/14/25, revealed the resident was cognitively intact, was dependent on staff to shower/bathe self, and the resident refused to transfer during the assessment reference period. Review of Resident #20's care plan, date initiated 08/29/23 and revised on 03/15/25, revealed Resident #20 had an ADL self care performance deficit related to morbid obesity. Resident #20 was dependent on staff for showering/bathing. There was no documentation in the care plan to indicate Resident #20 should not be showered and no documentation to indicate he preferred only bed baths. Further review of Resident #20's medical record revealed from 03/30/25 to 04/27/25 the resident either received a bed bath or refused to be bathed. The last weight recorded for Resident #20 was dated 04/04/25 and the weight was 711.0 pounds. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the product specification for MJM International PVCM1315 bariatric shower chair which the facility identified as being the bariatric shower chair located in the shower room on the unit where Resident #20 resided revealed the shower chair was made of PVC and had a weight capacity limit of 700 pounds. An interview with Resident #20 on 04/14/25 at 9:38 A.M. revealed he would love a shower, and if he received a shower, the facility staff would have a difficult time getting him out of the shower since it would feel so good. Resident #20 verified the staff did not shower him, they only gave him bed baths because he was told by the staff there was not a shower chair that would hold him. Interview on 04/16/25 at 7:23 A.M. with Certified Nursing Assistant (CNA) #550 revealed there was no way to safely shower Resident #20 in the shower room since the facility's bariatric shower chair would not be stable enough to support his weight. Observation of the facility's shower chairs and shower bed in all the shower rooms on 04/16/25 from 9:33 A.M. to 9:46 A.M. with Laundry and Housekeeping Manager (LHM) #603 revealed the largest shower chair was in the hall where Resident #20 resided and was made of white PVC (a synthetic resin made from the polymerization of vinyl chloride) pipe. There was a sticker on the chair indicating it was manufactured by MJM International but there was nothing on the bariatric chair indicating what the weight limit was for the chair, which was verified at the time of observation by LHM #603. Interview on 04/16/25 at 5:56 PM with the Director of Nursing (DON) confirmed the facility's bariatric shower chair had a weight limit of 700 pounds, and Resident #20 weighed more than the weight limit for the facility's bariatric shower chair. She went on to state she thought Resident #20 preferred bed baths, but if the resident wanted to take a shower, the facility did not have a safe way to shower the resident. Interview conducted on 04/17/25 approximately between 9:00 A.M. and 10:53 A.M. with DPM #516 revealed the facility could provide a bariatric shower chair to accommodate a resident who weighed between 700 and 900 pounds and it was made by the same manufacturer MJM International. Product specifications provided by the facility for MJM international Extra Wide PVC Bariatric Chair PVCM1315D8 revealed the chair was extra wide and reinforced at all stress related areas and had a weight capacity of 900 pounds. Review of the undated facility policy titled Resident Rights revealed it was the policy of the facility to provide resident centered care which would meet the physical needs of the residents and safety of the residents would be a top priority of care.		

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51525 Based on interviews and record review and review of facility policy, the facility failed to ensure privacy with mail correspondence for Resident #41. This affected one resident (#41) of one resident reviewed for privacy with mail. The facility census was 64. Findings include: Review of the medical record revealed Resident #41 was admitted to the facility on [DATE], and was his own responsible party. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15 indicating he was cognitively intact. Interview with Resident #41 on 04/17/25 at 9:26 A.M. revealed staff opened his mail on several occasions without his permission. The Activity Director #555 who was also present during this interview, confirmed that staff opened resident #41's mail if it looked like insurance or a bill. Interview with the Social Services Designee (SSD) #558 on 04/17/25 at 11:19 A.M. revealed she and the Business Office Manager (BOM) #534 went through the mail then gave it to the activities department to deliver. Interview with the BOM on 04/17/25 at 11:36 A.M. revealed the mail was brought to the SSD or BOM. The BOM stated she went through the mail and gave it to the activities department to deliver. The BOM confirmed she opened some mail when she first started but didn't any longer. Review of an undated facility policy titled Resident Rights stated residents have the right to have privacy in sending and getting mail and email.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to ensure the do not resuscitate (DNR) authorization form was completed in its entirety for Resident #51. This affected one resident (#51) of 22 residents reviewed for advanced directives. The facility census was 64. Findings include: Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, acute kidney failure, and major depressive disorder. Review of the uploaded documents in Resident #51's electronic health record revealed a do not resuscitate (DNR) authorization form signed and dated 03/22/24. The patient name, patient address, patient birthdate, and patient gender fields were all blank. The signature of the resident or representative was unable to be deciphered. There was no clear indication on the authorization as to whom the authorization was intended for. On 04/21/25 at 8:58 A.M., an interview with the Administrator verified there was no identifying information on the DNR authorization form and stated the form should have included the resident's name. The Administrator was unable to determine which resident the form was intended for.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on record review and interview the facility failed to ensure the Notice of Medicare Non-Coverage was acknowledged by the resident representative for residents with cognitive impairment. This affected two residents (#29 and #57) of five residents reviewed for beneficiary notices. The facility census was 64. Findings include: 1. Review of Resident #29's medical records revealed an admitted [DATE] with diagnosis including dementia. Resident #29 resided on the secured unit, and a niece was listed as Resident #29's representative. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had impaired cognition. Review of Resident #29's Notice of Medicare Non-Coverage revealed a date of non coverage of 10/11/24. Under the additional information section on the document was a hand written note dated 10/09/24 authored by Social Services Designee (SSD) #558 indicating a call was placed to Resident #29's niece and a message was left regarding last of day of coverage of 10/11/24. Below the additional information section the form stated please sign below to indicate you have received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO. The signature of patient or representative and date sections were blank indicating the notice had not been acknowledged by Resident # 29's representative. An interview on 04/22/25 at 10:59 A.M. with SSD #558 confirmed Resident #29's Notice of Medicare Non-Coverage was not signed and no additional efforts had been made to contact Resident #29's niece to confirm date of non coverage and notify of the right to appeal. SSD #558 stated she should have made additional attempts to contact Resident #29's representative as Resident #29 was unable to sign and understand the notice. 2. Review of Resident #57's medical records revealed an admitted [DATE]. Diagnoses included dementia and cognitive deficits. Resident #57 resided on the secured unit, and her grandson was assigned Power of Attorney (POA). Review of the MDS 3.0 assessment dated [DATE] revealed Resident #57 had impaired cognition. Review of Resident #57's Notice of Medicare Non-Coverage revealed a date of non coverage of 12/24/24 and a handwritten note authored by SSD #558 under the additional information section of the form included Resident #57's grandson had been contacted to explain discontinuation from speech therapy, the appeal process which he declined and Resident #57 was unable to sign the notice due to diagnoses of dementia, however Resident #57's signature was on on the form. (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/22/25 at 10:59 A.M. with SSD #558 confirmed she had authored the additional information section regarding Resident #57 was unable to sign due to diagnoses of dementia. SSD #558 verified the paperwork had Resident #57's signature and not the POA signature. SSD #558 stated she should not have allowed Resident #57 to sign acknowledgement of the Notice of Medicare Non-Coverage because Resident #57 would not understand what was being acknowledged and the grandson was the POA so his signature was required to acknowledge he was notified of non-coverage and the right to appeal.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42733 Based on observation and interview the facility failed to ensure a clean environment was maintained for Resident #56 and Resident #267 and failed to maintain comfortable water temperatures and at the required water temperature for Resident #11, #15, #19, #27, #33, #34, #52 and #54. This affected 10 residents (#11, #15, #19, #27, #33, #34, #52, #54, #56 and #54) with the potential to affect an additional 13 residents (#7, #14, #22, #23, #28, #31, #37, #42, #43, #45 #46, #60 and #114) residing on the 100 hall. The facility census was 64. Findings include: 1. Observation on 04/14/25 at 9:17 A.M. of Resident #56's room revealed Resident #56 was resting in bed and was noninterviewable due to drowsiness at the time of the observation. In Resident #56's bathroom the toilet was observed to have a large amount of black/green colored liquid stool on the toilet seat and in the toilet bowl. The observation was confirmed by Licensed Practical Nurse (LPN) #515. 2. Observation on 04/16/25 at 8:41 A.M. of Resident #267's bathroom revealed the toilet had dried stool on the toilet seat and inside the toilet bowl. The bathroom had a heavy odor of stale urine and there was a dark orange ring of residue surrounding the base of the toilet. The observation was confirmed by LPN #541. 46195 3. Review of the facility water temperature log provided by the Director of Plant Maintenance (DPM) #516 revealed a record of water temperatures between 01/01/25 and 04/14/25. The water temperatures had been checked in two different areas for each of the four hallways on 01/01/25, 01/06/25, 01/13/25, 02/17/25, and 03/10/25. On 01/13/25 the temperature recorded in Residents #34 and #54 room (on the 100 hallway) was 92 degrees Fahrenheit (F) and in Residents #42 and #46 room (on the 100 hallway) the temperature of the water was 90 degrees F. On 01/27/25 the water temperature taken of an unidentified area of the 100 hallway was 90 degrees F. There were no recorded temperatures on the log for the weeks of 01/20/25, 02/03/25, 02/10/25, 02/24/25, 03/03/25, 03/17/25, 03/24/25, or 04/07/25. Observations were conducted on 04/15/25 from 2:02 P.M. to 4:24 P.M. during an environmental tour with DPM #516 to obtain resident room water temperatures on the 100 hallway using DPM #516's facility thermometer. The following concerns were identified: In Resident #34 and #54's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the bathroom faucet using a facility thermometer and the water reached 93.9 degrees F as the highest temperature. The water was lukewarm to the touch. In Residents #27 and #33's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the bathroom faucet using a facility thermometer and the water reached 93.9 degrees F as the highest temperature. The water was luke warm to the touch. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In Residents #19 and #15's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the bathroom faucet and the water reached 95.0 degrees F as the highest temperature. The water was luke warm to the touch. In Resident #52's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the room faucet and the water reached 97.7 degrees F as the highest temperature. The water was lukewarm to the touch. Interviews at the time of the observations with DPM #516 confirmed the water coming out of the bathroom sinks on the 100 hallway was not warm enough. DPM #516 stated the temperature of the water should be between 105 and 120 degrees F. DPM #516 said he attributed the lukewarm temperatures to the hot water tank not being large enough to meet all the needs of the residents on the affected unit. DPM #516 stated the facility had recently replaced the mixing valve which had helped to increase the water temperatures on the 100 hallway. Interview on 04/15/25 at 4:35 P.M. with Resident #11, who resided on the 100 hallway, revealed her showers were just warm and she would like the water temperature to be warmer because it was not at a comfortable temperature for her. Interview on 04/24/25 at 9:22 A.M. with DPM #516 confirmed the missing weeks of recorded water temperatures. DPM #516 stated he was taking water temperatures weekly except he had missed the week of 04/07/25. DPM #516 stated he thought the program he was using to record the water temperatures was backing up his data, and he had no idea why the program hadn't backed up the water temperatures he was recording. DPM #516 confirmed there was no written evidence the water temperatures were being monitored weekly for the missing weeks of recorded water temperatures. DPM #516 confirmed the water temperatures dating back to January of 2025 to present did not meet the regulatory requirement for water temperatures. Review of undated facility policy titled Resident Rights revealed it was the policy of the facility to provide residents with resident centered care that meets the psychosocial, physical, and emotional needs of the residents. This deficiency represents non-compliance investigated under Complaint Number OH00164146.		

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, interview, and review of the facility policy, the facility failed to ensure admission paperwork was signed as required. This affected one resident (#214) of five residents reviewed for admission. The facility census was 64. Findings include: Review of the medical record for Resident #214 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, obstructive sleep apnea, respiratory failure with hypoxia, anxiety disorder, and hypertension. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 04/01/25, indicated Resident #214 admitted on [DATE] and had no cognitive impairment. Review of the admissions packet provided by the Administrator on 04/22/25 for Resident #214 revealed the admissions agreement, responsible party/resident representative agreement, agreement to arbitrate disputes, assignment of benefits, Medicare secondary payer determination, photograph consent, authorization to share medical information, vendor consultation consent, receipt of information, medical marijuana facility consent, patient authorization and consent for care, and admissions checklist were all signed on 04/22/25, which was 28 days after admission. On 04/22/25 at 3:15 P.M., an interview with the Administrator verified Resident #214's admissions paperwork was dated 04/22/25 and that admissions paperwork should have been completed at the time of admission. The Administrator stated the facility did not have a full time admissions coordinator and admissions paperwork was to be completed with residents by Mobile Admissions Coordinator #585 or the Administrator. Review of the facility's policy titled Resident Admission Policy, dated 10/05/20, revealed the Admissions Director or manager on duty would meet with residents or resident representatives to complete and sign all admission paperwork within 48 hours of the resident's admission and the Administrator would sign off on all completed admissions packets within 48 hours of the resident's admission.		

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NAME OF PROVIDER OR SUPPLIER Salem West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record reviews, interviews, and review of facility policy, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected the residents' status. This affected three residents (Residents #20, #21, and #38) out of 22 residents reviewed for accurate MDS assessments. The facility census was 64. Findings include: 1. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cognitive communication deficit, depression, and pseudobulbar affect. Review of Resident #38's quarterly MDS 3.0 assessment, dated 03/14/25, revealed Resident #38 was moderately impaired cognitively, had inattention behavior which was continuously present and did not fluctuate, was dependent on staff for transfers, did not walk, was dependent on staff to wheel her manual wheelchair, and had no falls since the prior MDS assessment, which was a quarterly assessment dated [DATE]. Further review of Resident #38's medical record revealed on 01/05/25 the resident had an unwitnessed fall and was found on knees in room hugging the mattress and on 01/10/25 had another unwitnessed fall and was found in room sitting on her buttocks. Interview on 04/21/25 at 3:21 P.M. with MDS Registered Nurse (RN) #504 confirmed Resident #38's quarterly MDS 3.0 assessment dated [DATE] had been incorrectly coded since Resident #38 had falls on 01/05/25 and 01/10/25 which occurred since the previous MDS assessment dated [DATE]. 2. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), obesity, and a history of pulmonary embolism. Review of Resident #21's physician's orders revealed an order dated 12/05/23 for oxygen at two liters per minute at bedtime for decreased pulse ox. Review of Resident #21's quarterly MDS 3.0 assessment, dated 03/13/25, revealed the resident was cognitively intact, had no behaviors including rejection of care, experienced shortness of breath while lying flat, and was not on any oxygen therapy. Review of Resident #21's March 2025 Treatment Administration Record (TAR) revealed the resident had received oxygen at two liters per minute at bedtime during the assessment reference period. Review of Resident #21's care plan, initiated on 03/15/24, revealed the resident had COPD with shortness of breath while lying flat with an intervention to provide oxygen therapy as ordered. Interview on 04/21/25 at 3:26 P.M. with MDS RN #504 stated, after reviewing Resident #21's medical record, Resident #21 had received oxygen therapy during the 03/13/25 MDS assessment reference period and confirmed the assessment had been incorrectly coded. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included morbid obesity, dependence on supplemental oxygen, bipolar disorder, schizoaffective disorder, atherosclerotic heart disease, and anxiety disorder. Review of Resident #20 physician orders revealed an order dated 04/17/24 for oxygen at two (liters per minute) via NC (nasal cannula) continuous. Review of Resident #20's quarterly MDS 3.0 assessment, dated 03/14/25, revealed the resident was cognitively intact, refused to transfer out of the bed, was short of breath while lying flat, and had not received oxygen therapy during the assessment reference period. Review of Resident #20's care plan initiated 09/17/24 revealed the resident was at risk for impaired oxygen exchange related to requirement of oxygen use. Interventions included oxygen via nasal cannula as ordered. Review of Resident #20's March 2025 TAR revealed the resident had been receiving oxygen at two liters per minute continuously during the quarterly 03/14/25 reference period with no refusals. Interview on 04/21/25 at 3:17 P.M. with MDS RN #504 confirmed, after reviewing Resident #20's medical record, Resident #20 had received oxygen therapy during the 03/14/25 quarterly MDS assessment's reference period, and the MDS assessment had been incorrectly coded. Review of the facility's undated policy titled Clinical Documentation Standards revealed nurses would follow the basic standard of practice for documentation which included but was not limited to providing a timely and accurate account of resident information in the medical record.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51525 Based on record review and interviews, the facility failed to develop a comprehensive care plan to identify triggers and effective interventions related to a diagnosis of Post-Traumatic Stress Disorder (PTSD) for Resident #42. This affected one resident (#42) of 22 residents reviewed for care plans. The facility census was 64. Findings include: Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with a diagnosis of PTSD, anxiety, unspecified psychosis and depression. Resident #42's wife was listed as the resident representative and Power of Attorney (POA) for Resident #42. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS also revealed Resident #42 demonstrated verbal and physical behavior symptoms directed at others one to three days per week. Review of the care plan for Resident #42, with a date initiated of 06/19/23 and date revised of 03/30/25, revealed there was no part of the care plan developed to address the diagnosis of PTSD to identify triggers and interventions to treat the PTSD. Interview with Resident #42's wife on 04/14/25 at 3:07 P.M. revealed Resident #42 was diagnosed with PTSD after serving as a medic in the Vietnam war and his triggers were loud noises, violence on television and being handled. Resident #42's wife confirmed Resident #42 had cognitive impairment and she had not been asked to help develop a care plan to address his PTSD. Interview with Director of Nursing on 04/23/25 at 3:13 P.M. confirmed a comprehensive care plan for PTSD was absent from Resident #42's medical record.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on medical record review, interviews, review of care plan schedules, and review of facility policy, the facility failed to develop a comprehensive care plan as required for Resident #264, failed to ensure there was documented proof in the medical record that care plan meetings with required participants were being held for Residents #20 and #21, and failed to ensure fall interventions were timely updated in the care plan for Resident #38. This affected four residents (#20, #21, #38, #264) out of 22 residents reviewed for care plans. The facility census was 64. Findings include: 1. Review of the closed medical record for Resident #264 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included ulcerative colitis, mild protein- calorie malnutrition, anorexia, pneumonia, dysphagia, cognitive communication deficit, atherosclerotic heart disease, bipolar disease, anxiety disorder, personality disorder, Alzheimer's disease, and major depressive disorder. Review of Resident #264's discharge return anticipated Minimum Data Set (MDS) 3.0 assessment, dated 03/20/25, revealed the residents short term memory was okay but had some difficulty in new situations with daily decision making, rejection of care occurred one to three days during the assessment reference period, required setup or clean up assistance for toileting hygiene, supervision or touch assistance for lower body dressing, personal and oral hygiene and transfers, partial or moderate assistance for showering/bathing self and walking ten feet. Review of Resident #264's care plan, initiated on 03/04/25, revealed the resident had impaired cognitive function. Interventions included communicating with resident/family/caregivers regarding needs; discussing concerns regarding confusion, disease process, nursing home placement with resident/family/caregiver; and encouraging resident to be involved in daily decision making and activities as able. Further review of the medical record for Resident #264 revealed there was no evidence of an interdisciplinary meeting including the resident and/or resident representative to develop a comprehensive care plan as required for Resident #264 during his stay from 02/26/25 to 03/20/25. Review of care conference schedules for January 2025 to March 2025 revealed Resident #264 had not been scheduled for a care conference between admission on 02/26/25 and discharge on 03/20/25. Interview on 04/21/25 at 9:11 A.M. with Social Service Designee (SSD) #558 revealed when a resident was admitted to the facility, she would schedule their care conference to be held sometime within three months of admission and would document in the progress notes when a care conference had been held. SSD #558 verified a care conference had not been held for Resident #264 since he had not been at the facility for three months, so his care plan was developed without having the care conference. Interview on 04/22/25 at 12:00 P.M. with the Director of Nursing (DON) revealed after an admission meeting, care conferences would be held quarterly. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included bipolar disorder, schizoaffective disorder, atherosclerotic heart disease, type two diabetes, anxiety disorder, essential hypertension, and morbid (severe) obesity due to excess calories. Review of Resident #20's quarterly MDS 3.0 assessment, dated 03/14/25, revealed the resident was cognitively intact; felt down, depressed, hopeless two to six days over the last two weeks of the assessment's reference period; rejected care one to three days of the assessment reference period; was dependent for toileting hygiene, shower/bath self, and refused to transfer out of the bed during the assessment reference period. Review of Resident #20's care plan, with an initiation date of 01/10/24, revealed Resident #20 was at risk for psychosocial well-being related to schizoaffective/bipolar disorder and depression. Interventions included allow resident time to answer questions and to verbalize feelings, perceptions, and fears; and assist/encourage/support resident to set realistic self-initiated goals. Interview on 04/14/25 at 9:40 A.M. with Resident #20 revealed he hadn't had a care plan meeting since he had been at the facility. He stated he had never been invited to a care conference meeting, and no one had come to his room to hold a care conference. Further review of Resident #20's medical record revealed there was no documentation indicating a care plan meeting had been held for Resident #20 between 03/25/24 and 04/23/25. Interview on 04/21/25 at 9:11 A.M. with SSD #558 revealed care conferences were held quarterly in the conference room. She stated the facility didn't have a sign-in sheet for the meetings, but she would document in the medical record's progress notes when care conferences had been held and who had attended the meetings. She confirmed there had been no documented proof in Resident #20's medical record that care plan conferences for the resident had been held over the past 12 months. 3. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included type two diabetes, atherosclerotic heart disease, unstable angina pectoris, chronic obstructive pulmonary disease (COPD), obesity, anxiety disorder, and depression. Review of Resident #21's quarterly MDS 3.0 assessment, dated 03/13/25, revealed the resident was cognitively intact, had no behaviors including rejection of care, required setup or clean up for eating and oral hygiene, was dependent for bed/chair to chair transfer, and sit to lying, lying to sitting, sit to stand, toilet transfer, and walk ten feet was not attempted during the assessment reference period. Review of Resident #21's careplan, initiated 12/06/23, revealed the resident used anti-anxiety medication due to anxiety disorder. Interventions included encourage to voice feelings and discuss coping skills. Further review of Resident #21's medical record revealed the resident had a care plan meeting on 03/06/24 which the resident, dietary, activity and SSD attended the meeting. There was not another documented care plan meeting until 02/03/25 (eleven months later) when a care plan meeting was held in Resident #21's room with the SSD to discuss community living. There was no evidence all required participants were at either care plan meeting. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/14/25 at 10:07 A.M. with Resident #21 revealed interdisciplinary care conferences were not being held for her. Interview on 04/21/25 at 9:11 A.M. with SSD #558 revealed care conferences were held quarterly in the conference room. She stated the facility didn't have a sign-in sheet for the meetings, but she would document in the medical record's progress notes when care conferences had been held and who had attended the meetings. She confirmed there had been no documented proof in Resident #21's medical record that care plan conferences for the resident had been held every three months over the past 12 months. 4. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, unspecified lack of coordination, cognitive communication deficit, depression, severe protein calorie malnutrition, and unsteadiness on feet. Review of Resident #38's quarterly MDS 3.0 assessment, dated 03/14/25, revealed Resident #38 was moderately impaired cognitively, had inattention behavior which was continuously present and did not fluctuate, was dependent on staff for transfers, did not walk, was dependent on staff to wheel her manual wheelchair, and had no falls since the prior MDS assessment, which was a quarterly assessment dated [DATE]. Review of Resident #38's fall care plan, initiated on 07/13/24, revealed the resident was at risk for falls related to having a history of falls. Interventions were to assess for falls on admission /readmission, quarterly, and as needed; educate resident or resident representative, if applicable on how to operate bed control/call light/television; ensure residents room is free of potential visible hazards; ensure bed locks are engaged; and perimeter mattress to bed at all times. Further review of Resident #38's medical record revealed on 11/01/24 the resident was found on floor in room next to bed with no injuries. On 01/05/25 the resident was found kneeling on her bedside mat holding on to her mattress with the left arm with no injuries. On 01/10/25 the resident was heard yelling out from room and was observed sitting on floor with back to bed with no injuries. Review of facility document titled Fall Follow Up-V5 dated 11/04/24 revealed for Resident #38's fall on 11/01/24 the resident had been educated on how to use the call light and the bed had been placed on the lowest level to help prevent future falls. Review of facility document titled Fall Follow Up-V5 dated 01/07/25 revealed for Resident #38's fall on 01/05/25 a fall mat had been placed beside the bed to help prevent future falls with injury. Review of facility document titled Fall Follow Up-V5 dated 01/10/25 revealed for Resident #38's fall on 01/10/25 non skid footwear had been added to help prevent future falls. Interview on 04/22/25 at 4:13 P.M. with the Director of Nursing (DON) confirmed Resident #38's fall care plan, initiated 07/13/24, had not been timely updated with the new interventions from Resident #38's falls on 11/01/24, 01/05/25, and on 01/10/25. and should have been. (continued on next page)		

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy Plan of Care Overview revealed the resident/representative would have the right to participate in the development and implementation of his/her own plan of care including but not limited to right to request meetings; right to identify individuals or roles to be included in the planning process; right to request revisions to care plan; right to participate in goal establishment and outcomes; and the right to the type, amount, frequency, duration of care or other factors related to the effectiveness of the plan of care; and right to be informed in advance of changes to the plan of care. The nurses were expected to review and revise the care plan of the residents they provide care for as the resident's condition warrants. This deficiency represents non-compliance investigated under Complaint Number OH00162382.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51525 Based on observation, record review and interview, the facility failed to ensure Resident #114 received staff assistance for showering, and failed to ensure timely incontinence care was provided for Resident #21, #23 and #42. This affected four residents (#114, #21, #23 and #42) of five residents reviewed for assistance with activity of daily living (ADL) needs. The facility census was 64. Findings include: 1. Review of the medical record revealed Resident #114 had an admitted [DATE] with diagnoses including multiple sclerosis, epilepsy, and paralytic syndrome. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #114 was dependent for showering and bathing. Review of Resident #114's care plan, date initiated 03/26/25, revealed Resident #114 had an ADL self-care performance deficient related to multiple sclerosis, schizophrenia and partial quadriplegia. Interventions included assistance of two or more helpers with bathing/showering due to total dependence on staff. An interview with Resident #114 on 04/14/25 at 2:16 P.M. revealed she hadn't had a shower in a week since moving to a new room, and as a result she was unable to wash her hair and her back. She further stated she asked her aide for a shower on dayshift and nightshift but was told she wasn't on the shower schedule so she could not get a shower. A follow up interview with Resident #114 on 4/15/25 at 2:17 P.M. revealed she still didn't have a shower and would like to have one. She stated she asked midnight shift and day shift and was told both times she was not on the list to be showered. An interview with Certified Nursing Assistant (CNA) #560 on 04/15/25 at 2:34 P.M. revealed there was a shower schedule for residents and if they were not on the shower schedule then they did not get a shower. CNA #560 stated Resident #114 was not on the shower schedule for Resident #114's hall so she had not given her a shower. CNA #560 showed the surveyor the shower schedule and verified Resident #114's name was not on shower schedule. CNA #560 stated she was unsure whose job it was to put residents on the schedule. CNA #560 stated she was unsure how long it would take to get any resident onto a shower schedule or what the process was for adding residents to the shower schedule. An interview with Resident #114 and CNA #502 on 04/16/25 at 10:36 A.M. revealed Resident #114 wet herself while outside this morning. CNA #502 confirmed and stated she got Resident #114 cleaned up afterward but did not give her a shower after her accident. CNA #502 also stated she was unsure how to get Resident #114 on the shower list. 2. Review of Resident #23's medical records revealed an admission of 11/20/19. Diagnoses included muscle weakness, need for personal care assistance and wheelchair dependent. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment dated [DATE] revealed Resident #23 had no cognition score due to Resident #23 was rarely understood. Resident #23 was dependent with toileting, bathing and personal hygiene and was incontinent of bowel and bladder. Review of the care plan dated 02/28/25 revealed Resident #23 was incontinent of bowel and bladder. Interventions included provide incontinence care as needed. Observation of incontinence care on 04/22/25 at 9:18 A.M. for Resident #23 with CNA #543 and CNA #700 revealed Resident #23 was in a wheelchair in his room. CNA #543 stated Resident #23 had been up in his wheelchair since she had arrived to start her shift at 6:00 A.M. and stated she had not provided Resident #23 with incontinence care yet. Observation revealed CNA #543 and CNA #700 had used a hooyer lift (mechanical lift) to get Resident #23 out of his wheelchair. Resident #23's hooyer pad, pants, and shirt were observed to have been saturated with urine. Interviews with CNA #542 and CNA #700 confirmed Resident #23 was saturated with urine and neither were able to state when Resident #23 had last received incontinence care and stated residents should be checked for incontinence at least every two hours. Resident #23 was not interviewable. 3. Review of Resident #42's medical records revealed an admitted [DATE]. Diagnoses included muscle weakness, need for personal care assistance and dementia. Review of the care plan dated 03/31/25 revealed Resident #42 was incontinent of bowel and bladder. Interventions included provide incontinence care as needed. Review of the MDS assessment dated [DATE] revealed Resident #42 had impaired cognition. Resident #42 was incontinent of bowel and bladder. Observation of incontinence care on 04/22/25 at 9:26 A.M. for Resident #42 with CNA #543 and CNA #700 revealed Resident #42 was in a wheelchair in his room. CNA #543 stated Resident #42 had been up since she had arrived to start her shift at 6:00 A.M. and stated she had not provided Resident #42 with incontinence care yet. Observation further revealed Resident #42's incontinence brief was saturated with stale smelling dark urine. CNA #543 and CNA #700 confirmed the observation and stated residents should be checked for incontinence at least every two hours and both were unable to state when Resident #42 had last received incontinence care. Resident #42 was not interviewable. [NAME] 4. Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included obesity, muscle weakness and the need for assistants with personal care. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 required substantial/maximal assistants for bed mobility, dependent for transfers to/from wheelchair and dependent for toileting hygiene. Resident #21 was always incontinent of urine and frequently incontinent of bowels. Record review of the care plan dated 12/05/23 revealed Resident #21 had an activity of daily living (ADL) self-care performance deficit due to immobility and morbid obesity. Interventions included for toileting hygiene, Resident #21 was totally dependent of two or more helpers who do all the effort. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/23/25 at 11:06 A.M. with CNA #524 and #574 complete incontinent care for Resident #21 revealed Resident #21 was lying in bed. Resident #21 had a strong foul odor of urine. Observation revealed Resident #21's sheet and bath blanket Resident #21 was lying on was saturated with urine half way up her back and to her mid lower thighs. The brief was totally saturated and the blanket covering her was wet with urine. CNA #524 and #574 confirmed Resident #21 had a strong odor of urine and Resident #21's bedding and brief was saturated. Resident #21 revealed the last time she was checked or changed was 5:00 A.M. CNA #524 confirmed she was Resident #21's primary caregiver and confirmed this was the first time she checked or changed Resident #21 on her shift. CNA #524 confirmed she started her shift at 6:00 A.M. An interview on 04/23/25 at 11:27 A.M. with the Director of Nursing (DON) revealed each resident who was incontinent of the bowel or bladder would be checked every two hours to verify if they were incontinent, then changed if needed. If the resident was sleeping, they would still need to be checked. An interview on 04/23/25 at 11:43 A.M. with Resident #21 revealed she stated, they don't come in and change me like they should. Resident #21 revealed she never refused to be changed, when CNA #524 brought her breakfast tray in around 8:00 A.M. she asked to be changed. CNA #524 said she had to wait to get help, so she would do it after breakfast. Resident #21 revealed she ate her breakfast then fell back to sleep while waiting to be changed. Resident #21 stated, it makes me feel disgusting, it happens every day. An interview on 04/23/25 at 11:46 A.M. with CNA #524 revealed she stated, I did take her (Resident #21) breakfast tray in at 8:00 A.M., and she (Resident #21) did ask to be changed. I told her I would have to wait to get someone, we can't do her with one, it takes a while to find someone, the other aids were busy. Review of the facility policy titled, Routine Resident Care, undated, revealed it is the policy of the facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of the facility. This deficiency represents non-compliance investigated under Complaint Number OH00164146 and OH00162382.		

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 04/29/2025
NAME OF PROVIDER OR SUPPLIER Salem West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and review of facility policy, the facility failed to ensure therapeutic activities as scheduled were being provided to residents on the secured unit. This had the potential to affect all 13 residents (#3, #8, #10, #18, #29, #30, #48, #55, #50, #56, #58, #59, #61) who resided on the secured unit. In addition, the facility failed to ensure Resident #20 was provided one-to-one activities of interest, and Resident #50 was provided routine therapeutic activities for socialization. This affected two residents (#20 and #50) of three residents reviewed for activities. The facility census was 64. Findings include: 1. Review of the April 2025 activity calendar posted on the wall in the hallway of the secure unit revealed activities scheduled on the unit for 04/16/25 included chair yoga at 9:00 A.M., chronicles /brain games at 9:30 A.M., games with friends at 10:00 A.M., guess your weight at 10:30 A.M., cards with friends at 1:30 P.M., sit and chat at 2:30 P.M., socialize and snack at 3:00 P.M., and TED talk at 5:30 P.M. Observation on 04/16/25 at 10:45 A.M. revealed there was no activity being held on the secured unit. An interview on 04/16/25 at 10:51 A.M. with Certified Nursing Assistant (CNA) #563, who was working on the unit that day, verified there had not been any activities on the secure unit that morning and she was not sure why. An interview on 04/16/25 at 11:06 A.M. with CNA #550 revealed CNA #550 worked on the secured unit and other units in the facility, and CNA #550 stated most of the time scheduled activities were not being held on the secured unit. Observation of the secure unit on 04/16/25 at 5:33 P.M. revealed there were two residents sitting in the secure unit lounge and two residents walking up and down the hallway. There was no TED talk being held. At the time of the observation, CNA #563 confirmed the activity at 5:30 P.M. was not being held, and stated that since there had been an outing that day, the only activity which had been held on the unit that day was snacks being passed out 30 minutes after lunch. Interview on 04/21/25 with Activity Director (AD) #555 revealed when there were outings scheduled, the whole activity team would go on the outings, and when they go out on outings, the activities staff would put out self-initiated activities for the residents for the day. AD #555 stated the activity staff were only at the facility until 5:00 P.M., and activities held after 5:00 P.M. were the responsibility of the receptionist and the aides, but the receptionist position was currently vacant and the facility had new aides who may not have known they were supposed to do the activities scheduled after 5:00 P.M. AD #555 confirmed most of the evening activities were not currently being held and activities on the secured unit on 04/16/25 were not implemented due to an outing that day. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy titled Secured (Locked) Unit revealed residents residing on the unit would be provided activities designed for cognitively impaired to decrease boredom and provide an outlet for expression. 2. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included bipolar disorder, schizoaffective disorder bipolar type, type two diabetes, and anxiety disorder. Review of the modification of annual Minimum Data Set (MDS) 3.0 assessment, dated 10/05/24, revealed Resident #20 felt it was somewhat important to have books, newspapers and magazines, listen to music he liked, keep up with the news, do favorite activities, and to go outside to get fresh air when the weather was good, and he felt it was not very important do things with groups of people or participate in religious activities. Review of the quarterly MDS 3.0 assessment, dated 03/14/25, revealed Resident #20 was cognitively intact, felt down, depressed, or hopeless two to six days over the last two weeks. The resident refused to transfer from bed/chair during the assessment reference period. Review of the care plan initiated on 08/29/23 revealed Resident #20 was independently capable of pursuing activities of interest without intervention from staff. Resident #20 would make informed decisions regarding group activities, events, one-on-one activities, and independent pursuits. Interventions included assist with transport to activities as needed, encourage attendance to entertainment programs, invite resident to scheduled activities, provide one-on-one room visits if unable to attend out of room events, provide a schedule of activities as available; and provide activity materials of interest. Further review of the medical record for Resident #20 revealed that under the Tasks: Activity Participation, dated 03/23/25 to 04/16/25, it was documented Resident #20 received 1:1/Conversation/Social Time/Family Visit only one day which was 04/01/25. For the remainder of the days within that date range, Resident #20 participated in beverage/snack cart/socials four days on 03/23/25, 03/26/25, 04/11/25, and 04/16/25, and eleven days of relaxation/self-directed activities on 03/24/25, 03/25/25, 03/26/25, 03/27/25, 03/28/25, 03/30/25, 03/31/25, 04/02/25, 04/03/25, 04/04/25 and 04/05/25 . An interview on 04/14/25 at 9:36 A.M. with Resident #20 revealed the activity staff did not provide him one-to-one activities that met his interests. Resident #20 stated the activity staff would bring a daily chronicle but did not provide an actual one-to-one activity. Resident #20 stated he would like to have one-to-one interaction with the activity staff so he had someone to have daily conversations with because all he had to do in his room was either watch television or visit with his mom. An interview on 04/21/25 at 10:19 A.M. with AD #555 revealed Resident #20's activity program consisted of one-to-one activities because he preferred to stay in his room and not attend group activities. When asked if AD #555 had a record of one-to-one activities provided to Resident #20, AD #555 stated one-to-one activities were not being documented so there was no record to show that Resident #20 was being provided any activities that met his interests. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Activities Program, revealed it was the policy to provide resident center care that met the psychological, physical, and emotional needs and concerns of the residents. The activity program would be scheduled daily and would consist of individual and small and large group activities which are designed to meet the needs and interests of each resident which included individualized activities. 3. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, chronic obstructive pulmonary disease, type two diabetes mellitus, dementia, schizoaffective disorder, anxiety disorder, depression, adult failure to thrive, bipolar disorder, and suicidal ideations. Review of the modification of Resident #50's admissions MDS 3.0 assessment, dated 07/19/24, revealed it was somewhat important to have books, newspapers, and magazines to read, to listen to music, keep up with the news, to get fresh air when the weather was good, and to participate in religious services. The resident indicated it was not important at all to be around animals such as pets. Review of the care plan, initiated 07/15/24, revealed Resident #50 was self-directed for activities in and out of room daily and was dependent on staff for activities, cognitive stimulation, and socialization. Interventions included assist with transport to activities as needed; assure the activities are compatible with resident's physical and cognitive capabilities, encourage attendance to entertainment programs, large and small group activities, volunteer demonstrations and religious activities, and provide a schedule of activities available. An interview on 04/14/25 at 10:46 A.M. with Resident #50 revealed she was alert and able to carry on reciprocal conversation. Resident #50 stated she felt like she was locked on the unit, and there was nothing for her to do. Observation on 04/16/25 at 10:45 A.M. revealed there was no activity being held on the unit and Resident #50 was lying in her bed. Interview at the time of the observation with Resident #50 revealed she hadn't attended any activities that morning since no one had come down to invite her to the activity. Interview on 04/16/25 at 10:51 A.M. with Certified Nursing Assistant (CNA) #563, who was working on the unit that day, revealed there had not been any activities on the secure unit that morning and she was not sure why. Observation of the secure unit on 04/16/25 at 5:33 P.M. revealed there were two residents sitting in the secure unit lounge and two residents walking up and down the hallway. There was no TED talk being held. At the time of the observation, CNA#563 confirmed the activity at 5:30 P.M. was not being held, and stated that since there had been an outing that day, the only activity which had been held on the unit that day was snacks being passed out 30 minutes after lunch. Interview on 04/16/25 at 11:06 A.M. with CNA #550, who would work on secure unit at times, revealed most of the time scheduled activities were not being held on the secured unit. (continued on next page)		

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/21/25 with Activity Director (AD) #555 confirmed activities on the secured unit were not being provided as scheduled on the activity calendar for the secured unit, and activities held after 5:00 P.M. were the responsibility of the receptionist and the aides, but the receptionist position was currently vacant and the facility had new aides who may not have known they were supposed to do the activities scheduled after 5:00 P.M. AD #555 confirmed most of the evening activities were not currently being held and activities on the secured unit on 04/16/25 were not implemented due to an outing that day. Review of the undated facility policy titled Secured (Locked) Unit revealed residents residing on the unit would be provided activities designed for cognitively impaired to decrease boredom and provide an outlet for expression.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, record review and review of facility policy, the facility failed to ensure smoking materials were in a secured area when not in use for Resident #26 and Resident #41, failed to ensure fall interventions were implemented after a fall for Resident #38, and failed to ensure water was at a safe temperature for Resident #36 and #267. This affected five residents (#26, #41, #38, #36, and #267) of seven residents reviewed for accidents/hazards. The facility census was 64. Findings include: 1. Review of Resident #26's medical records revealed an admitted [DATE]. Diagnoses included tobacco use. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition and was independent with ambulation. Review of the care plan dated 03/20/25 revealed Resident #26 used nicotine products. Interventions included educate resident on designated smoking area and provide safe smoking devices if required. Review of the smoking assessment dated [DATE] revealed Resident #26 was an independent smoker. Observation on 04/14/25 at 1:40 P.M. revealed Resident #26 was ambulating in the hallway and he had pulled a cigarette and a lighter out of his pocket and had proceeded to walk outside towards the smoking area. An interview with Licensed Practical Nurse (LPN) #566 at 1:43 P.M. on 04/14/25 revealed residents smoking materials were to be secured and stated even if residents are considered independent smokers they were still not permitted to keep smoking materials in their possession. During this interview LPN #566 had entered Resident #26's room and had asked if he had smoking materials on him and Resident #26 stated he did. LPN #566 proceeded to remove the smoking materials from Resident #26 and educated Resident #26 about turning his smoking materials into the nurse for safety. 2. Review of Resident #41's medical records revealed an admitted [DATE]. Diagnoses included muscle weakness, lack of coordination and need for personal care assistance. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #41 required set up assistance with ambulation. Review of the care plan dated 02/20/25 revealed Resident #41 used nicotine products. Interventions included provide safe smoking devices if required. Review of the smoking assessment dated [DATE] revealed Resident #41 was an independent smoker. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 04/14/25 at 1:43 P.M. with LPN #566 revealed Resident #41 was also considered an independent smoker and he likely had his smoking materials on him. On 04/14/25 at 3:03 P.M. an interview with the Director of Nursing (DON) revealed Resident #41 was checked to see if he had any smoking materials on him and the DON had to confiscate smoking materials from Resident #41 and educate Resident #41 on not keeping his smoking materials in his possession. Review of facility policy titled Resident Smoking Guidelines undated revealed staff will store smoking materials in a secured area when not in use, and will be maintained by the facility staff and provided to the resident on request. 46195 3. An observation was conducted during tour of the physical environment on 04/15/25 from 2:02 P.M. to 4:18 P.M. with Director of Plant Maintenance (DPM) #516 on the 400 hallway. DPM #516 was observed taking water temperatures from the bathroom faucet in the room of Resident #36 and #267 using a calibrated facility thermometer. After letting the water run for approximately two minutes, DPM #516 read the water temperature at 130 degrees Fahrenheit (F). The water felt hot to touch and DPM #516 verified the water was too hot and immediately shut off the water on the 400 hallway and went to call the [NAME]. Review of the facility document titled Log Book Documentation Inspect Air and Water Temperatures, dated 01/01/25 to 04/14/25 revealed the facility wasn't consistently checking the facility water temperatures on a weekly basis. Review of the recorded temperatures revealed the water temperatures had been checked on 01/01/25, 01/06/25, 01/13/25, 01/27/25, 02/17/25, and 03/10/25. The water temperatures ranged between 90 degrees F to 118 degrees F. There were no recorded temperatures on the log for the weeks of 01/20/25, 02/03/25, 02/10/25, 02/24/25, 03/03/25, 03/17/25, 03/24/25, or 04/07/25. An interview on 04/15/25 at 4:24 P.M. with DPM #516 revealed he stated the water temperatures should be between 105 and 120 degrees F. An interview on 04/15/25 at 4:40 P.M. with Resident #36 revealed she stated the water is very hot and I have to add cold water so I don't burn my hand. An interview on 04/16/25 at 12:07 P.M. with Certified Nursing Assistant (CNA) #550 revealed she had given a shower to Resident #25 on Monday (4/14/25), who resided on the 400 hall, and CNA #550 said she had to make sure to add enough cold water because the hot water was too hot and the resident could have been burnt if she had not added enough cold water. An observation on 04/16/25 from 4:14 P.M. to 4:20 P.M. on the 400 hallway with DPM #516 revealed he was using the calibrated facility thermometer to take water temperatures from the bathroom faucet for Resident #36 and Resident #267 and the water temperature was 105 degrees F. An interview with DPM #516 during the observation revealed he had to make an adjustment on the hot water tank in order for the water temperature to be back in compliance. An interview on 04/23/25 at 7:27 A.M. with the DON verified there had been no residents who had been burned by hot water in the facility. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 04/24/25 at 9:22 A.M. with DPM #516 confirmed the missing weeks of recorded water temperatures. He stated he was taking water temperatures weekly except he had missed the week of 04/07/25. He stated he thought the digital program he was using to record the water temperatures was backing up his data, and he had no idea why the program hadn't backed up the water temperatures he was recording. He confirmed there was no proof water temperatures were being taken weekly with the missing weeks of recorded water temperatures. Review of the undated facility policy Resident Rights revealed safety of residents, visitors, and employees was a top priority of care. 4. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (a stroke), unspecified lack of coordination, cognitive communication deficit, depression, severe protein calorie malnutrition, and unsteadiness on feet. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/14/25, revealed the resident was moderately impaired cognitively, exhibited inattention behavior which was continuously present and did not fluctuate; was dependent on staff for transfers and had not attempted to walk ten feet during the assessment reference period. Review of Resident #38's fall care plan, initiated on 07/13/24, revealed the resident was at risk for falls related to having a history of falls. Interventions were to assess for falls on admission /readmission, quarterly, and as needed; educate resident or resident representative, if applicable on how to operate bed control/call light/television; ensure residents room is free of potential visible hazards; ensure bed locks are engaged; and perimeter mattress to bed at all times. Further review of Resident #38's medical record revealed on 01/05/25 the resident was found kneeling on her bedside mat holding on to her mattress with the left arm with no injuries. Review of facility document Post Fall Evaluation - V4, dated 01/05/25, revealed Resident #38 had an unwitnessed fall with no injuries on 01/05/25 at 3:40 P.M. The resident was not experiencing any pain and had no skin concerns. When asked what happened the resident stated she didn't know . When asked if she rolled out of bed the resident replied yes. The suspected root cause was noted to be no safety awareness. The facility's immediate intervention to prevent falls was to check on the resident every one hour for the night and the Director of Nursing (DON) would discuss an appropriate intervention the next morning. Further review of Resident #38's medical record revealed there was no documented proof one hour checks had been completed during the night of 01/05/25. Interview on 04/22/25 at 4:13 PM with the DON verified the one hour checks for Resident #38 should have been put in place, but there was no proof it had been done.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, record review and interview the facility failed to ensure indwelling urinary catheters were emptied in a timely manner to prevent back flow of urine for Resident #16. This affected one resident (#16) of three residents observed for catheters. The facility identified nine residents (#16, #51, #5, #2, #19, #45, #32, #53 and #31) as having indwelling urinary catheters. The facility census was 64. Findings include: Review of Resident #16's medical records revealed an admitted [DATE]. Diagnoses included need for personal care assistance and open wound of the lower back and pelvis. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #16 had intact cognition. Resident #16 required maximum assistance with toileting and had an indwelling catheter for urination and was incontinent of bowel. Review of the care plan dated 02/28/25 revealed Resident #16 had a urinary catheter. Interventions included provide catheter care every shift and as needed. Review of current physician orders for April 2025 revealed to document output every shift. Review of output documentation revealed no documented output prior to 04/16/25 at 3:40 P.M. Observation on 04/16/25 at 8:31 A.M. revealed Resident #16 was sleeping in her bed and the urinary catheter bag was observed to be completely filled up with urine. An interview was conducted on 04/16/25 at 8:31 A.M. during the observation of Resident #16 with Licensed Practical Nurse (LPN) #541 who confirmed Resident #16's full catheter bag. LPN #541 further confirmed there was an amount of 2000 cc's of urine in Resident #16's bag. LPN #541 stated catheter bags were to be emptied before they had become full as to prevent any backflow of urine. At the time of the observation and interview with LPN #541, LPN #541 had informed the Director of Nursing (DON) of Resident #16's full urinary catheter, the DON observed Resident #16's full catheter bag and had proceeded to empty the bag. 42011		

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, interview, and review of facility policy, the facility failed to ensure weekly weights were being obtained as ordered by the physician to monitor nutrition status for Resident #38 and #42. This affected two residents (#38 and #42) out of four residents reviewed for nutrition. The facility census was 64. Findings include: 1. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, cognitive communication deficit, depression, and severe protein calorie malnutrition. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/14/25, revealed the resident was moderately impaired cognitively, exhibited continuous inattention behavior; required partial/moderate assistance for eating; had a significant weight loss which was not prescribed; and was on a therapeutic diet. Review of a weight change progress note dated 03/19/25 at 2:54 P.M. revealed Resident #38's current weight of 215.3 pounds triggered a significant weight loss of 14 percent weight loss over 180 days. Recommendations included weekly weights. Review of Resident #38's physician's orders revealed an order dated 03/19/25 for weekly weights every Wednesday for four weeks (start date of 03/19/25 and end date of 04/09/25). Review of Resident #38's March 2025 Medication Administration Record (MAR) revealed weekly weights were signed off as completed on 03/19/25 and on 03/26/25 but no actual measurement of weight was documented. Review of Resident #38's April 2025 MAR revealed weekly weights were signed off as completed on 04/02/25 and 04/09/25 but no actual measurement of weight was documented. Further review of Resident #38's weights in the medical record revealed the resident's weight had been obtained on 03/20/25 and 04/04/25. There were no weights for 03/26/25 and 04/09/25. Interview on 04/23/25 at 10:16 A.M. with Registered Dietitian (RD) #578 verified weekly weights had not been obtained as ordered between 03/19/25 and 04/09/25 for Resident #38. 2. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including Parkinson's disease, dementia, type two diabetes mellitus, anxiety disorder, and post-traumatic stress disorder. Review of the nutrition note dated 03/13/25 at 2:44 P.M. revealed Resident #42 had experienced a significant weight loss of five percent in one month and weekly weights were ordered to monitor weight trends. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for Resident #42 dated 03/13/25 revealed an order for weekly weights due to weight loss (ordered on 03/13/25 with an end date of 04/16/25). Review of Resident #42's MAR for March and April 2025 revealed weekly weights were signed off as completed on 03/19/25, 03/26/25, 04/02/25, 04/09/25, and 04/16/25 but no actual measurement of weight was documented. Review of the Resident #42's documented weights in the medical record revealed weights were documented on 03/20/25 and 04/04/25. There were no other weights recorded between 03/19/25 and 04/16/25. On 04/22/25 at 5:18 P.M., an interview with the Director of Nursing (DON) verified weekly weights were not obtained as ordered between 03/19/25 and 04/16/25 for Resident #42. Review of the undated facility policy titled Resident Height and Weight revealed weights would be obtained monthly or as ordered by the physician or practitioner.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review the facility failed to ensure Resident #26 received proper and physician ordered care of a feeding tube site to prevent potential for skin irritation and infection. This affected one resident (#26) of two residents reviewed for feeding tubes. The facility census was 64. Findings include: Review of Resident #26's medical records revealed an admitted [DATE]. Diagnoses included surgical interventions of the digestive system. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition. Review of the care plan dated 03/20/25 revealed Resident #26 required the use of a feeding tube. Interventions included check placement of feeding tube and monitor tube feedings. Review of physician orders for April 2025 revealed an order dated 12/02/24 to cleanse Resident #26's feeding tube site with normal saline and apply drain gauze at bed time. Observation on 04/21/25 at 12:02 P.M. revealed Resident #26's tube feeding site had a soiled, undated gauze dressing around the site. Interview with Licensed Practical Nurse (LPN) #538 at the time of observation revealed she had changed Resident #26's tube feed dressing on 04/17/25, which was the last day she had worked with Resident #26. Interview with Resident #26 at time of observation revealed LPN #538 was the last one who had changed his tube feeding dressing several days ago.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interviews, record reviews, and review of facility policy, the facility failed to ensure oxygen tubing was changed weekly. This affected three residents (#5, #20, and #21) out of three residents reviewed for respiratory care. The facility identified eleven residents (#5, #9, #17, #19, #20, #21, #23, #25, #27, #31, and #43) as having a physician order for oxygen. The facility census was 64. Findings include: 1. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), obesity, and a history of pulmonary embolism. Review of Resident #21's physician orders revealed orders dated 12/05/23 for oxygen at two liters per minute at bedtime for decreased pulse ox (a device used to measure blood oxygen and pulse) and to change oxygen tubing every week and PRN (as needed). Review of Resident #21's care plan, initiated on 03/15/24, revealed the resident had COPD with shortness of breath while lying flat. Interventions included elevate head of bed as needed to prevent shortness of breath while lying flat, monitor vitals and report abnormal findings to medical provider, and oxygen therapy as ordered. Change tubing per facility policy. Observation on 04/14/25 at 10:00 A.M. revealed Resident #21's oxygen tubing was dated 04/06/25. Interview on 04/14/25 at 10:37 A.M. with Certified Nursing Assistant (CNA) #550 confirmed Resident #21's oxygen tubing was dated 04/06/25 and stated she thought oxygen tubing should be changed weekly. 2. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included morbid obesity, dependence on supplemental oxygen, bipolar disorder, schizoaffective disorder, atherosclerotic heart disease, and anxiety disorder. Review of Resident #20's physician orders revealed orders dated 04/17/24 for oxygen at two (liters per minute) via NC (nasal cannula) continuous and to change oxygen tubing and humidifier every seven days and PRN. Review of Resident #20's care plan initiated 09/17/24 revealed the resident was at risk for impaired oxygen exchange related to requirement of oxygen use. Interventions included monitor for signs/symptoms of respiratory distress and report to medical provider as needed, oxygen via nasal cannula as ordered, provide ear protectors to oxygen tubing if applicable, and raise head of bed to promote optimal lung expansion. Observation on 04/14/25 at 9:51 A.M. revealed Resident #20's oxygen tubing was dated 04/05/25. Interview on 04/14/25 at 10:37 A.M. with CNA #550 confirmed the oxygen tubing was dated 04/05/25 and stated she thought the oxygen tubing needed changed weekly. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and nonspecific abnormal finding of lung field, anxiety disorder, and dependence on supplemental oxygen. Review of Resident #5's physician order revealed an order dated 10/17/23 for oxygen at three liters/minute continuous through nasal canula may titrate to keep oxygen saturation level 90 percent or greater, and an order dated 07/09/22 to change oxygen tubing every week and PRN. Review of Resident #5's care plan, initiated on 07/13/22, revealed the resident has COPD with shortness of breath while lying flat, seasonal allergies, and a lung mass. Interventions included elevate head as needed to prevent shortness of breath while lying flat, observe for signs and symptoms of COPD, monitor vitals, and oxygen therapy as ordered, change tubing per facility policy. Observation on 04/14/25 at 9:21 A.M. revealed Resident #5's oxygen tubing was dated 04/05/25. Interview on 04/14/25 at 10:38 A.M. with CNA #550 confirmed the oxygen tubing was dated 04/05/25 and stated she thought the oxygen tubing needed changed weekly. Interview on 04/23/25 at 7:27 AM with the Director of Nursing (DON) confirmed oxygen tubing should be changed weekly and dated when changed. Review of undated facility policy titled Supplemental Oxygen using Nasal Cannula, revealed nasal cannula and tubing were to be changed weekly or when soiled and labeled with date when opened.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, record review, and review of the Payroll Based Journal (PBJ) and facility assessment, the facility failed to provide sufficient nursing staff to meet the total care needs of all residents for their highest practicable physical, mental and psychosocial well-being. This affected four residents (#21, #23, #38 and #42) of five residents reviewed for assistance with activity of daily living (ADL) needs and had the potential to affect all residents in the facility. The facility census was 64. Findings included: 1. Review of the Payroll Based Journal (PBJ) Staffing Report for Fiscal Year Quarter four (07/01/24 to 09/30/24) for the facility revealed a concern triggered for a one-star staffing rating indicating inadequate staffing hours. Review of the Facility Assessment (FA), dated 04/03/25, as provided by the Administrator revealed persons involved in completing the assessment were not identified by first or last name on the FA and there was no documentation to indicate if and when the FA had been reviewed by the Quality Assurance and Performance Improvement (QAPI) committee. The average census was identified as 61 residents. On page 10 was listed Physical Disabilities and the number of residents requiring staff assistance for ADLs based on current census which indicated out of a total of 61 residents 59 needed staff assistance for toileting hygiene, and 53 needed a minimum of set-up/clean-up assistance or a higher degree of assistance with eating. In Part 3, section 3.1 of the FA, the staffing plan did not address the number of direct care staff across all shifts needed to address resident acuity/care needs, as the section addressing staffing of aides and nurses on each unit was blank and instead gave a report of the fourth quarter staffing reported in the payroll based journal. The section on Staff Survey and Individual Staff Assignments was left blank. An interview on 04/14/25 at 8:21 A.M. with Licensed Practical Nurse (LPN) #538 revealed staffing was a concern because sometimes there were only two nurses in the facility and when there were only two nurses LPN #538 was unable to complete resident treatments. An interview on 04/14/25 at 8:43 A.M. with Certified Nursing Assistant (CNA) #601 revealed at times there will only be one CNA on the behavior unit and that was not enough to monitor and care for the residents. An interview on 04/14/25 at 11:10 A.M. with CNA #550 revealed there was usually one aide on the 400 hall so CNA #550 could not perform timely resident care. An interview on 04/16/25 at 7:23 A.M. with CNA #550 revealed because there are not enough staff there are days the residents who need every two hour checks for incontinence care will have to wait for three and a half hours before CNA #550 can find the time to go and change them. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 04/16/25 at 7:53 A.M. with LPN #503 revealed when there are two nurses for the whole facility LPN #503 is unable to get medications passed on time to the residents. LPN #503 stated sometimes there is a third nurse to help pass medications until 10:00 A.M. but then that nurse leaves. An observation on 04/17/25 from 5:15 A.M. to 6:00 A.M. of the nursing staff in the facility compared to the posted schedule revealed there were two nurses and four CNA present in the facility. The posted schedule indicated there were three nurses consisting of one LPN from 6:00 P.M. to 10:30 P.M., one LPN from 6:00 P.M. to 6:30 A.M., one Registered Nurse (RN) from 6:00 P.M. to 6:30 A.M. and five CNA from 6:00 P.M. to 6:00 A.M. An interview on 04/17/25 at 5:18 A.M. with Registered Nurse (RN) #510 revealed there were two CNAs and one nurse for the 100/200 halls because the third CNA had left early. When asked if there was sufficient staff to meet all the resident care needs RN #510 replied we try our best. An interview on 04/17/25 at 5:21 A.M. with CNA #560 revealed there was not enough help on the 100/200 halls and more CNAs were needed because most of the residents needed a mechanical lift transfer which required at least two staff. CNA #560 stated with only two CNA on the 100/200 hall the staff can't get the residents up, can't get check and changes/incontinence care done and can't get showers completed. An interview on 04/17/25 at 6:00 A.M. with CNA #570 revealed she worked all shifts in the facility and when night shift is working short the residents have to wait for day shift to start before the care can be provided. CNA #570 stated when residents can get up and get showered was based on staff availability so showers do not get done as scheduled. An interview on 04/17/25 at 8:34 A.M. with LPN #541 revealed sometimes they are the only staff member on the 100/200 halls because the CNA are feeding residents. An interview on 04/17/25 at 8:40 A.M. with the Director of Nursing (DON) revealed staffing levels in the facility meet the minimum required 2.5 hours of direct care. The DON verified the night shift had four CNA and two nurses in the facility which did not match the daily posted schedule. An interview on 04/22/25 at 9:18 A.M. with CNA #543 revealed there were only two CNA on the 100/200 hall so there were several residents who had not been provided incontinence care yet. CNA #543 stated there needed to be three to four CNA on the 100/200 hall because there were over 30 residents who needed assistance. An interview on 04/23/25 at 12:29 P.M. with the Administrator verified the Facility Assessment was incomplete and did not have a staffing plan to address resident acuity needs. 2. Review of Resident #23's medical records revealed an admission of 11/20/19. Diagnoses included muscle weakness, need for personal care assistance and wheelchair dependent. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had no cognition score due to Resident #23 was rarely understood. Resident #23 was dependent with toileting, bathing and personal hygiene and was incontinent of bowel and bladder. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the care plan dated 02/28/25 revealed Resident #23 was incontinent of bowel and bladder. Interventions included provide incontinence care as needed. Observation of incontinence care on 04/22/25 at 9:18 A.M. for Resident #23 with Certified Nursing Assistant (CNA) #543 and CNA #600 revealed Resident #23 was in a wheelchair in his room. CNA #543 stated Resident #23 had been up in his wheelchair since she had arrived to start her shift at 6:00 A.M. and stated she had not provided Resident #23 with incontinence care yet. Observation revealed CNA #543 and CNA #600 had used a hooyer lift (mechanical lift) to get Resident #23 out of his wheelchair. Resident #23's hooyer pad, pants, and shirt were observed to have been saturated with urine. Interviews with CNA #543 and CNA #600 confirmed Resident #23 was saturated with urine and neither were able to state when Resident #23 had last received incontinence care and stated residents should be checked for incontinence at least every two hours. CNA #543 stated there were not enough staff to complete her assigned duties timely. Resident #23 was not interviewable. 3. Review of Resident #42's medical records revealed an admitted [DATE]. Diagnoses included muscle weakness, need for personal care assistance and dementia. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #42 had impaired cognition. Resident #42 was incontinent of bowel and bladder. Review of the care plan dated 03/31/25 revealed Resident #42 was incontinent of bowel and bladder. Interventions included provide incontinence care as needed. Observation of incontinence care on 04/22/25 at 9:28 A.M. for Resident #42 with CNA #543 and CNA #600 revealed Resident #42 was in a wheelchair in his room. CNA # 543 stated Resident #42 had been up since she had arrived to start her shift at 6:00 A.M. and stated she had not provided Resident #42 with incontinence care yet. Observation further revealed Resident #42's incontinence brief was saturated with stale smelling dark urine. CNA #543 and CNA #600 confirmed the observation and stated residents should be checked for incontinence at least every two hours and both were unable to state when Resident #42 had last received incontinence care. CNA #543 stated were not enough staff to complete her assigned duties timely. Resident #42 was not interviewable. 46195 4. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiplegia following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, cognitive communication deficit, depression, and severe protein calorie malnutrition. Review of Resident #38's quarterly MDS 3.0 assessment, dated 03/14/25, revealed the resident was moderately impaired cognitively, exhibited continuous inattention behavior; required partial/moderate assistance for eating; had a significant weight loss which was not prescribed; and was on a therapeutic diet. Review of a weight change progress note dated 03/19/25 at 2:54 P.M. revealed Resident #38 current weight of 215.3 pounds triggered a significant weight loss of 14 percent weight loss over 180 days with poor intake of meals. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #38's care plan, initiated on 07/24/24, revealed the resident had a potential for altered nutrition status/ nutrition related problems due to having a significant weight loss and being obese. Interventions included provide food in individual bowls to enhance independence in feeding ability; resident to be in the dining room for all meals; assistance with meals as needed; and provide diet and supplements per medical provider's orders. Observations on 04/15/25 from 8:07 A.M. until 9:01 A.M. revealed Resident #38 was sitting in the dining room at a table by herself with food in bowls placed in front of her. There were two certified nursing assistants feeding other residents in the dining room. Resident #38 was observed making no attempt to feed herself. The resident was either watching other residents feed themselves or was dozing off. At 8:52 A.M. Certified Nursing Assistant (CNA) #505 came over to assist Resident #38 with her meal. An interview on 04/15/25 at 8:55 A.M. with CNAs #505 revealed there were two staff members in the dining room to feed four residents and assist a couple of residents. CNA #505 confirmed residents were not being fed or assisted in a timely manner, which included Resident #38, due to not enough staff to provide assistance. 5. Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included obesity, muscle weakness and the need for assistants with personal care. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 required substantial/maximal assistants for bed mobility, dependent for transfers to/from wheelchair and dependent for toileting hygiene. Resident #21 was always incontinent of urine and frequently incontinent of bowels. Record review of the care plan dated 12/05/23 revealed Resident #21 had an activity of daily living (ADL) self-care performance deficit due to immobility and morbid obesity. Interventions included for toileting hygiene, Resident #21 was totally dependent of two or more helpers who do all the effort. Observation on 04/23/25 at 11:06 A.M. with CNA #524 and #574 complete incontinent care for Resident #21 revealed Resident #21 was lying in bed. Resident #21 had a strong foul odor of urine. Observation revealed Resident #21's sheet and bath blanket Resident #21 was lying on was saturated with urine half way up her back and to her mid lower thighs. The brief was totally saturated and the blanket covering her was wet with urine. CNA #524 and #574 confirmed Resident #21 had a strong odor of urine and Resident #21's bedding and brief was saturated. Resident #21 revealed the last time she was checked or changed was 5:00 A.M. CNA #524 confirmed she was Resident #21's primary caregiver and confirmed this was the first time she checked or changed Resident #21 on her shift. CNA #524 confirmed she started her shift at 6:00 A.M. An interview on 04/23/25 at 11:27 A.M. with the Director of Nursing (DON) revealed each resident who was incontinent of the bowel or bladder would be checked every two hours to verify if they were incontinent, then changed if needed. If the resident was sleeping, they would still need to be checked. (continued on next page)		

Department of Health & Human Services
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 04/23/25 at 11:43 A.M. with Resident #21 revealed she stated, they don't come in and change me like they should. Resident #21 revealed she never refused to be changed, when CNA #524 brought her breakfast tray in around 8:00 A.M. she asked to be changed. CNA #524 said she had to wait to get help, so she would do it after breakfast. Resident #21 revealed she ate her breakfast then fell back to sleep while waiting to be changed. Resident #21 stated, it makes me feel disgusting, it happens every day. An interview on 04/23/25 at 11:46 A.M. with CNA #524 revealed she stated, I did take her (Resident #21) breakfast tray in at 8:00 A.M., and she (Resident #21) did ask to be changed. I told her I would have to wait to get someone, we can't do her with one, it takes a while to find someone, the other aids were busy. Review of the facility policy titled, Routine Resident Care, undated, revealed it is the policy of the facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of the facility. This deficiency represents non-compliance investigated under Complaint Number OH00164146 and OH00162382.		

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 51525 Based on interview and employee file reviews, the facility failed to conduct performance evaluations for Certified Nursing Assistants (CNA) as required. This had the potential to affect all 64 residents residing in the facility. Findings include: Review of the personnel file for Certified Nursing Assistant (CNA) #552 revealed a hire date of 09/04/25 and revealed no quarterly performance evaluation had been completed. Review of the personnel file for CNA #502 revealed a hire date of 12/28/23 and no quarterly or annual performance evaluation had been completed. Review of the personnel file for CNA #551 revealed a hire date of 03/28/24 and no quarterly or annual performance evaluation had been completed. Review of the personnel file for CNA #562 revealed a hire date of 09/05/24 and no quarterly performance evaluation had been completed. An interview on 04/23/25 at 11:10 A.M. with the Human Resource Manager confirmed the findings of performance evaluations absent from CNA #552, #502, #551 and #562 employee files.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review the facility failed to ensure residents were free from significant medication errors. This affected two residents (#35 and #37) of five residents reviewed for medication administration. The facility census was 64. Findings include: 1. Review of Resident #35's medical records revealed an admitted [DATE]. Diagnoses included dementia and depression Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had intact cognition. Review of the care plan dated [DATE] revealed Resident #35 had behaviors that included verbal disagreements with her roommate regarding the television. Interventions included administer medications as ordered. Resident #35 used anti-depressant medications. Interventions included provide medications per physician orders. Review of Resident #35's current physician orders for [DATE] revealed an order to administer Ativan (anti-anxiety medication) one milligram (mg) at bedtime. Review of the progress note dated [DATE] timed 11:40 P.M. authored by Registered Nurse (RN) #554 revealed Ativan was out of stock. RN #554 had contacted the pharmacy and had been informed Resident #35's Ativan script was expired and a new script was required for refill. Review of a progress note dated [DATE] timed 1:00 A.M. authored by Nurse Practitioner (NP) #701 revealed a one time dose of Ativan was ordered and to follow up with the house provider for further orders. Review of a progress note dated [DATE] timed 3:08 A.M. authored by RN #506 revealed she was awaiting a code from the pharmacy for Resident #35's Ativan. Review of a progress note dated [DATE] timed 5:12 A.M. authored by Licensed Practical Nurse (LPN) #566 revealed Resident #35's Ativan was unavailable. Pharmacy was notified and stated the medication would be delivered on the first drop. Review of a progress note dated [DATE] timed 2:57 P.M. authored by LPN #538 revealed Resident #35 had asked about her Ativan due to she had not received the medication for four nights. The progress note stated the nurse practitioner had been notified and stated she would write a new script. Review of a progress note dated [DATE] timed 1:04 A.M. authored by RN #510 revealed Resident #35's Ativan was unavailable and a script was required. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #35's Medication Administration Record (MAR) for [DATE] revealed Ativan had not been documented as being administered on [DATE], [DATE] and [DATE]. Resident #35's Ativan had been documented as being administered on [DATE] by RN #521, however the medication had not been available at that time. Interview on [DATE] at 1:30 P.M. with LPN #538 revealed Resident #35 had approached her earlier that day and had asked about her Ativan. LPN #538 stated she had been unaware Resident #35 had not received her Ativan due to it was scheduled to be administered on the evening shifts. LPN #538 stated Resident #35 had informed her she had not received the Ativan for the last four nights. Interview on [DATE] at 10:53 A.M. with the Director of Nursing (DON) revealed she had been informed Resident #35's Ativan had not been available and was not administered, however was unable to provide an explanation as to why it had not been administered and stated she would inform the physician. Interview on [DATE] at 10:58 A.M. with Resident #35 revealed she had not had her sleeping pills for several nights. Resident #35 stated she was not sure what the sleeping pill was called, however stated the nurses had told her the medication had been out of stock. Resident #35 stated she had not slept for the past three nights due to she had not been given her medication. 2. Review of Resident #37's medical records revealed an admitted [DATE]. Diagnoses included anxiety and dementia. Review of Resident #37's physician orders for [DATE] revealed to administer Hydroxyzine (antihistime, also used to treat anxiety) 25 milligrams (mg) in the morning and at bedtime for anxiety. Observation of medication administration on [DATE] at 7:51 A.M. with RN #554 revealed he had obtained a medication card from the medication cart that had Resident #7's name on the top for the medication Hydroxyzine in the amount of 50 mg tablets. RN #554 had popped the 50 mg Hydroxyzine out of the medication card and had added it to the other four medications that he had already had in the medication cup for Resident #37. RN #554 had approached Resident #37's doorway and upon surveyor intervention he had been asked to return to his medication cart. RN #554 was asked to verify the medication card he had used to obtain the Hydroxyzine and RN #554 had verified the medication card had belonged to Resident #7. RN #554 had then checked Resident #37's medication orders and had verified Resident #37 was ordered Hydroxyzine, however it was ordered for 25 milligrams. RN #554 had then taken the 50 mg tablet of Hydroxyzine out of Resident #37's medication cup and had placed it in another cup and stated he would administer that dose to Resident #7. RN #554 stated Resident #37's medication card was in a different spot and stated he had not looked at the name or the milligrams on the medication card prior to obtaining the medication.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview and record review the facility failed to ensure lab work had been completed timely and according to physician order. This affected one resident (#15) of two residents reviewed for laboratory services. The facility census was 64. Findings include: Review of Resident #15's medical records revealed an admitted [DATE]. Diagnoses included dementia, muscle weakness and need for personal care assistance. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #15 had impaired cognition. Review of a progress note dated 04/17/25 timed 3:24 P.M. authored by Licensed Practical Nurse (LPN) #566 revealed new orders were received to obtain a urinalysis and blood work. Review of physician orders dated 04/17/25 revealed orders for blood work and urinalysis. Review of the document titled Biomedical Laboratories dated 04/21/25 revealed Resident #15's blood specimen was collected on 04/21/25 and all results for the blood tests were pending. There was no collection for urinalysis. Interview on 04/21/25 at 8:53 A.M. with Licensed Practical Nurse (LPN) #566 and the Director of Nursing (DON) confirmed Resident #15 had orders to collect blood work and urine. LPN #566 verified the blood specimen was collected on 04/21/25 and there was no collection for urinalysis. LPN #566 stated she was unsure why the lab work had not been completed as ordered by the physician.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review, review of the facility diet spread sheet, and review of facility policy, the facility failed to ensure Resident #42 received foods consistent with a dysphagia advanced diet to meet individual needs. This affected one resident (#42) out of four residents reviewed for nutrition. The facility identified six residents (#14, #27, #30, #42, #43, and #266) ordered a dysphagia advanced diet. The facility census was 64. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including Parkinson's disease, dementia, and Alzheimer's disease. Review of Resident #42's physician orders revealed an order dated 01/13/25 for Regular diet, Dys (dysphagia) Adv (advanced) texture, Thin liquids consistency, Fortified hot cereal QD (every day) w/(with) breakfast, Fortified mashed potatoes BID (twice a day) w/ lunch and dinner. Review of Resident #42'S annual Minimum Data Set (MDS), dated [DATE], revealed Resident #42 was severely impaired cognitively, exhibited inattention and disorganized behavior, required partial/moderate assistance from staff for eating, had no swallowing concerns during the assessment reference period, had a significant weight loss which had not been prescribed, and received a therapeutic and a mechanically altered diet. Review of Resident #42's care plan revealed the resident had a potential for altered nutrition related to being overweight, needing a mechanically altered diet per speech recommendations, and having a severe weight loss. Interventions included observe for signs and symptoms of aspiration (when anything other than air gets into the airways)/dysphagia (difficulty swallowing) such as choking, coughing, pocketing food, loss of liquids/solids from mouth when eating/drinking and difficulty/pain when swallowing, provide meals per diet order, position resident properly for eating/swallowing, and speech therapy evaluation and treat as needed. Review of the facility diet spread sheet titled Salem [NAME] Healthcare Center Diet Guide Sheet for Week Two Wednesday (04/16/25) revealed residents on a Dysphagia Advanced diet were to be served one half cup of chopped Brussel sprouts instead of whole Brussel sprouts for lunch. Observation on 04/16/25 at 12:15 P.M. revealed a family member of Resident #42 was feeding Resident #42 his lunch in the south unit dining room and was observed asking staff if Resident #42 should have been served whole Brussel sprouts. The family member indicated to the staff she was having difficulty cutting up a Brussel sprout using a spoon. Review of Resident #42's diet slip at the time of observation revealed the resident was on a Regular-Dys Advance diet and was supposed to have received chopped Brussel sprouts with the meal. An interview on 04/16/25 at 12:17 P.M. with Certified Nursing Assistant (CNA) #601 verified Resident #42 had received whole intact Brussel sprouts instead of chopped Brussel sprouts. (continued on next page)		

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/16/25 at 12:22 P.M. with Regional District Manager #602 revealed residents on a Dysphagia Advanced diet should have received chopped Brussel Sprouts instead of whole Brussel sprouts for lunch on 04/16/25. Review of the facility policy titled Meal Distribution, revised February 2023, revealed all meals would be assembled in accordance with the individualized diet order, and nursing staff would be responsible for verifying meal accuracy of resident's meals prior to delivery to the resident. This deficiency represents non-compliance investigated under Complaint Number OH00164146.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, record review, job description review, and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all 64 residents who resided in the facility. Findings include: Review of facility document titled Position Description for position of Executive Director revealed the Administrator had signed the job description on 05/02/23. The description revealed the purpose of this position was to provide leadership to all staff to assure that care standards were met and the highest degree of quality resident care was provided at all times. The position description indicated the executive director must function as both a team member, team leader, and supervisor to ensure that work was accomplished and quality of care was delivered and had the authority, responsibility, and accountability for the overall operation of the facility. Major accountabilities and supporting actions of the position included but was not limited to: monitor operations to provide assurance of compliance with standards of practice, responsible for reviewing/evaluating and monitoring all staff on a regular basis to assure competence, achievement of goals, supervise and ensure care was provided in accordance with applicable standards of practice, state practice acts, and state and federal regulations. Review of facility document titled Position Description for position of Director of Nursing Services revealed the Director of Nursing (DON) had signed job description on 03/17/25. The description revealed the purpose of the position was to provide leadership to the nursing staff to assure that care standards were met and the highest degree of quality resident care was provided at all times. The position must function as a team member, team leader, and supervisor to ensure that work was accomplished and quality of care was delivered. Job duties and responsibilities included but were not limited to: make sure there was sufficient nursing levels to ensure delivery of quality resident care, ensure all nursing staff followed established department policies, monitor job performance to assure the staff were performing their work assignments within acceptable nursing standards, develop and maintaining a good working rapport with inter-department personnel as well as other departments to assure that the department services and activities could be maintained to meet the needs of the residents, assist in evaluating employee performance, inspect the nursing service areas and practices for compliance with current applicable regulations, assume the authority, responsibility, and accountability of directing the nursing service department, ensure all resident care would be provided in a dignified and respectful manner, supervise and may participate in the development of a written care plan and may review resident care plans for appropriate resident problems, approaches, goals, and revisions, ensure that a clean, comfortable and safe environment for residents was maintained at all times and resident needs were met, supervise and ensure care provided was in accordance with applicable standards of practice, state practice acts, and state and federal regulations (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the annual and complaint survey, observations, record reviews and interviews resulted in concerns related to the overall operation of the facility including but not limited to sufficient staffing, completion of performance evaluation for nursing services, completion of the facility assessment, monitoring the function of resident call system, monitoring of safe and comfortable water temperatures, and therapeutic activities. The facility failed to provide evidence administrative staff, including the Administrator and/or DON had effective systems in place to timely identify and correct quality, care and environmental concerns as follows: A.The facility failed to ensure adequate staff to provide timely and adequate care for residents. Review of the Payroll Based Journal (PBJ) Staffing Report for Fiscal Year Quarter four (07/01/24 to 09/30/24) for the facility revealed a concern triggered for a one-star staffing rating indicating inadequate staffing hours. Review of the Facility Assessment (FA), dated 04/03/25, as provided by the Administrator revealed In Part 3, section 3.1 of the FA, the staffing plan did not address the number of direct care staff across all shifts needed to address resident acuity/care needs, as the section addressing staffing of aides and nurses on each unit was blank and instead gave a report of the fourth quarter staffing reported in the payroll based journal. The section on Staff Survey and Individual Staff Assignments was left blank. 1.Observation of incontinence care on 04/22/25 at 9:18 A.M. for Resident #23 with Certified Nursing Assistant (CNA) #543 and CNA #600 revealed Resident #23 was in a wheelchair in his room. CNA #543 stated Resident #23 had been up in his wheelchair since she had arrived to start her shift at 6:00 A.M. and stated she had not provided Resident #23 with incontinence care yet. Observation revealed CNA #543 and CNA #600 had used a hoyer lift (mechanical lift) to get Resident #23 out of his wheelchair. Resident #23's hoyer pad, pants, and shirt were observed to have been saturated with urine. Interviews with CNA #543 and CNA #600 confirmed Resident #23 was saturated with urine and neither were able to state when Resident #23 had last received incontinence care and stated residents should be checked for incontinence at least every two hours. CNA #543 stated there had not been enough staff at time to complete her assigned duties timely. Resident #23 was not interviewable. 2. Observation of incontinence care on 04/22/25 at 9:28 A.M. for Resident #42 with CNA #543 and CNA #600 revealed Resident #42 was in a wheelchair in his room. CNA # 543 stated Resident #42 had been up since she had arrived to start her shift at 6:00 A.M. and stated she had not provided Resident #42 with incontinence care yet. Observation further revealed Resident #42's incontinence brief was saturated with stale smelling dark urine. CNAs #543 and #600 confirmed the observation and stated residents should be checked for incontinence at least every two hours and both were unable to state when Resident #42 had last received incontinence care. CNA #543 stated there had not been enough staff at time to complete her assigned duties timely. Resident #42 was not interviewable. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observations on 04/15/25 from 8:07 A.M. until 9:01 A.M. revealed Resident #38 was sitting in the dining room at a table by herself with food in bowls placed in front of her. There were two certified nursing assistants feeding other residents in the dining room. Resident #38 was observed making no attempt to feed herself. The resident was either watching other residents feed themselves or was dozing off. At 8:52 A.M. CNA #505 came over to assist Resident #38 with her meal. Interview on 04/15/25 at 8:55 A.M. with CNA #505 stated there were only two staff members in the dining room to feed four residents and assist a couple of residents. She confirmed residents were not being fed or assisted in a timely manner, which included Resident #38. 4. Observation on 04/23/25 at 11:06 A.M. with CNA #524 and #574 complete incontinence care for Resident #21 revealed Resident #21 was lying in bed. Resident #21 had a strong foul odor of urine. Observation revealed Resident #21's sheet and bath blanket Resident #21 was lying on was saturated with urine half way up her back and to her mid lower thighs. The brief was totally saturated and the blanket covering her was wet with urine. CNA #524 and #574 confirmed Resident #21 had a strong odor of urine and Resident #21's bedding and brief was saturated. Resident #21 revealed the last time she was checked or changed was 5:00 A.M. CNA #524 confirmed she was Resident #21's primary caregiver and confirmed this was the first time she checked or changed Resident #21 on her shift. CNA #524 confirmed she started her shift at 6:00 A.M. An interview on 04/23/25 at 11:43 A.M. with Resident #21 revealed she stated, they don't come in and change me like they should. Resident #21 revealed she never refused to be changed, when CNA #524 brought her breakfast tray in around 8:00 A.M. she asked to be changed. CNA #524 said she had to wait to get help, so she would do it after breakfast. Resident #21 revealed she ate her breakfast then fell back to sleep while waiting to be changed. Resident #21 stated, it makes me feel disgusting, it happens every day. An interview on 04/23/25 at 11:46 A.M. with CNA #524 revealed she stated, I did take her (Resident #21) breakfast tray in at 8:00 A.M., and she (Resident #21) did ask to be changed. I told her I would have to wait to get someone, we can't do her with one, it takes a while to find someone, the other aids were busy. Additional staff interviews conducted intermittently during the survey from 04/14/25 at 8:15 A.M. to 04/22/25 at 9:18 A.M. with eight direct care staff (Licensed Practical Nurse #538, #503, #541 and CNA #601, #550, #560, #570 and #543) revealed all of them voice concerns related to insufficient staffing affecting resident care regarding lack of timely resident checks, incontinence care, showers, medication pass and treatments. B.The facility failed to conduct performance evaluations for Certified Nursing Assistants (CNAs) who were due for required performance evaluations. Review of four employee files who were due for performance evaluations revealed CNAs #502, # 551, #552, and #562 had not had their performance evaluations. An interview on 04/23/25 at 11:10 A.M. with the Human Resource Manager confirmed the findings of performance evaluations absent from CNA #552, #502, #551 and #562 employee files. C. The facility failed to ensure the facility assessment was completed thoroughly and accurately. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility assessment, dated 04/03/25, revealed the following concerns: there was no indication who participated in the review and revision of the facility assessment. multiple sections of the facility assessment were incomplete as evidenced by blank spaces where information was needed to prepare a complete and thorough facility assessment. the certified bed capacity was incorrectly listed as 90 certified beds On 04/23/25 at 12:29 P.M., an interview with the Administrator stated she had no involvement in completing the facility assessment revision and it was completed by a corporate staff member, whom she was unable to name. The Administrator verified the revision date was listed as 04/03/25, confirmed the multiple blank spaces throughout the facility assessment, and confirmed the certified bed capacity should have been listed as 80 not 90. On 04/23/25 at 12:54 P.M., an interview with the Administrator stated she personally completed the 2025 facility assessment, which contradicted her previous statement that she had no involvement. The Administrator also stated she received input from the Director of Nursing (DON) when completing the facility assessment. On 04/23/25 at 1:00 P.M., an interview with the DON stated she did not recall being involved in revising the facility assessment. The DON confirmed the revision date for the facility assessment of 04/03/25 was after she became the DON and verified the missing and incorrect information in the provided facility assessment. D. The facility failed to ensure the resident's call system unit on the secured unit had an audible sound at all times so residents on the secured unit could call staff for assistance when needed. Observations during an environmental tour on 04/15/25 between 2:02 P.M. and 4:24 P.M. with Director of Plant Maintenance #516 revealed when a call light was pressed in Residents #8 and #58's room on the secure unit, the light outside the room lit up but there was no audible sound coming from the call system unit sitting on the nurse's station. Licensed Practical Nurse (LPN) #503, who was sitting at the nurse's station where the call system unit was sitting on the counter, confirmed the light outside the room had come on but she heard no audible sound coming from the emergency call system unit. LPN #503 stated the reason why there was no sound coming from the call system was because the volume on the unit had been turned down. Once LPN #503 turned up the volume on the call system unit, there was an audible sound coming out of the system when the call light was activated. LPN #503 verified if the volume was turned down, any of the resident call lights on the unit would not audibly notify staff the call light was activated. Interview on 04/15/25 at 2:57 P.M. with DPM #516 revealed he had noticed on other occasions the call system units had the sound turned off or way down so it could not be heard on the unit by staff. E. The facility failed to monitor water temperatures to ensure water was at safe and comfortable temperature at all times. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation during an environmental tour of the water temperatures in residents' rooms on 04/15/25 from 2:02 P.M. to 4:18 P.M. with Director of Plant Maintenance (DPM) #516 revealed after the water had been running out of the bathroom faucet in Residents #36 and #267's room for approximately two minutes, DPM #516 took the facility's digital thermometer and temped the water at 130 degrees Fahrenheit (F). The water felt hot to touch and DPM #516 verified the water was too hot and immediately shut off the water on the 400 hallway and went to call the [NAME]. In Resident #34 and #54's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the bathroom faucet using a facility thermometer and the water reached 93.9 degrees F as the highest temperature. The water was lukewarm to the touch. In Residents #27 and #33's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the bathroom faucet using a facility thermometer and the water reached 93.9 degrees F as the highest temperature. The water was luke warm to the touch. In Residents #19 and #15's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the bathroom faucet and the water reached 95.0 degrees F as the highest temperature. The water was luke warm to the touch. In Resident #52's room, after running the water for approximately two minutes, DPM #516 took the temperature of the water coming out of the room faucet and the water reached 97.7 degrees F as the highest temperature. The water was lukewarm to the touch. Interview on 04/15/25 at 4:24 P.M. with DPM #516 stated the water temperatures should be between 105 and 120 degrees F. Review of the facility water temperature log provided by the Director of Plant Maintenance (DPM) #516 revealed a record of water temperatures between 01/01/25 and 04/14/25. The water temperatures had been checked in two different areas for each of the four hallways on 01/01/25, 01/06/25, 01/13/25, 02/17/25, and 03/10/25. On 01/13/25 the temperature recorded in Residents #34 and #54 room (on the 100 hallway) was 92 degrees Fahrenheit (F) and in Residents #42 and #46 room (on the 100 hallway) the temperature of the water was 90 degrees F. On 01/27/25 the water temperature taken of an unidentified area of the 100 hallway was 90 degrees F. There were no recorded temperatures on the log for the weeks of 01/20/25, 02/03/25, 02/10/25, 02/24/25, 03/03/25, 03/17/25, 03/24/25, or 04/07/25. This was confirmed by DPM #516 on 04/24/25 at 9:22 A.M. when he stated there was no proof water temperatures were being taken weekly with the missing weeks of recorded water temperatures because the program he used was not backing up the data. F. The facility failed to ensure all residents were provided therapeutic activities as scheduled and, in the evenings, to meet their needs and preferences. Review of the April activity calendar posted on the wall of hallway of the secure unit revealed activities scheduled on the unit for 04/16/25 included chair yoga at 9:00 A.M., chronicles /brain games at 9:30 A.M., games with friends at 10:00 A.M., guess your weight at 10:30 A.M., cards with friends at 1:30 P.M., sit and chat 2:30 P.M., socialize and snack at 3:00 P.M., and TED talk at 5:30 P.M. Observation on 04/16/25 at 10:45 A.M. revealed there was no activity being held on the secured unit. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 04/16/25 at 10:51 A.M. with Certified Nursing Assistant (CNA) #563, who was working on the unit that day, verified there had not been any activities on the secure unit that morning and she was not sure why. Observation of the secure unit on 04/16/25 at 5:33 P.M. revealed there were two residents sitting in the secure unit lounge and two residents walking up and down the hallway. There was no [NAME] talk being held. At the time of the observation, Certified Nursing Assistant (CNA)#563 confirmed the activity at 5:30 P. M. was not being held. Interview on 04/21/25 with Activity Director #555 revealed the activity staff were only at the facility until 5:00 P.M., and activities held after 5:00 P.M. were the responsibility of the receptionist and the aides. She went on to state the receptionist position was currently vacant, and the facility had new aides who may not have known they were supposed to do the activities scheduled after 5:00 P.M. Activity Director #555 confirmed most of the even activities were not currently being held.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 44808 Based on review of the facility assessment and staff interview, the facility failed to ensure a complete and accurate facility assessment was developed with active involvement of the required participants. This had the potential to affect all 64 residents residing in the facility. Findings include: Review of the Facility Assessment (FA), dated 04/03/25, revealed the following concerns: There were no persons named to identify required participants involved in completing the FA, as that section was left blank. The date the assessment was reviewed with the Quality Assurance Performance Improvement (QAPI) committee was blank indicating it had not been reviewed by QAPI. On page four, line four the facility resources needed to provide competent care for residents had several blank spaces intended for identification of laboratory services, x-ray services, food services, laundry services, nursing agency, electronic medical records, staff scheduling, and other contracted services. On page six, the certified bed capacity was incorrectly listed as 90 certified beds. On page 23, there were several blank spaces including the frequency of the clinical wound nurse practitioner's assessments and treatments, the frequency of the facility's designated wound nurse assessments and treatments, and specification as to who would be responsible for completing wound treatments and progression monitoring on the weekends. On page 24, there were several blank spaces including specification of observed food practices in the facility, meal times, and open dining times and days. On page 25, there were several blank spaces including specification of spiritual or religious programs offered, when and where spiritual or religious services would be held, what equipment if any would be provided for spiritual or religious services, frequency of facility activities, and whether any culturally relevant activities would be offered. On page 27, there were several blank spaces including identification of any facility staffed behavioral health specialists and availability of the behavioral health specialist. On page 28, there were several blank spaces including dates of staff trainings on behavioral health in the previous 24 months, identification of the group providing psychological or behavioral health services, frequency of behavioral health visits, whether or not services are provided for addiction services and frequency of sessions if applicable, and specification of days or times for activities provided in the dementia care unit and general residential care unit. (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On page 29, there are several blank spaces including whether or not dialysis services are provided on-site, the availability of respiratory staff, and specification of the company providing ancillary services such as dental, audiology, podiatry, and optometry. On page 30, there are two blank spaces intended to specify the schedule of the facility's risk nurse and the schedule of the facility's social services staff. In Part 3, section 3.1 of the FA starting on page 34, the staffing plan did not address the number of direct care staff across all shifts needed to address resident acuity/care needs, as the section addressing staffing of aides and nurses on each unit was blank and instead gave a report of the fourth quarter staffing reported in the payroll based journal. The section on Staff Survey and Individual Staff Assignments was left blank. On page 46, the assessment includes instructions to list contracts, memoranda of understanding, and other agreements with third parties, include a description of the process for overseeing those services and how those services will meet resident needs and regulatory requirements, list health information technology resources, describe how the facility will securely transfer health information to other health care providers, describe how downtime procedures are developed and implemented, describe how the facility ensures residents and their representatives can access their records upon request and obtain copies within required time-frames, describe the evaluation process of the infection prevention and control program, and provide the facility-based and community-based risk assessment utilizing an all-hazards approach for emergency preparedness. Although the instructions and prompts were listed, this information was not included in the facility assessment itself. On 04/23/25 at 12:29 P.M., an interview with the Administrator stated she had no involvement in completing the facility assessment revision and it was completed by a corporate staff member, whom she was unable to name. The Administrator verified the revision date was listed as 04/03/25, confirmed the multiple blank spaces throughout the facility assessment, and confirmed the certified bed capacity should have been listed as 80 not 90. On 04/23/25 at 12:54 P.M., an interview with the Administrator stated she personally completed the 2025 facility assessment, which contradicted her previous statement that she had no involvement. The Administrator also stated she received input from the Director of Nursing (DON) when completing the facility assessment. On 04/23/25 at 1:00 P.M., an interview with the DON stated she did not recall being involved in revising the facility assessment. The DON confirmed the revision date for the facility assessment of 04/03/25 was after she became the DON and verified the missing and incorrect information in the facility assessment.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on medical record reviews, interviews, review of signed arbitration agreements, and review of facility policy, the facility failed to ensure the arbitration agreements were explained in a way the residents understood prior to the residents signing the agreement. This affected five residents (#20, #21, #26, #51 and #214) out of five residents reviewed for arbitration agreements and had the potential to affect all 26 residents (#1, #11, #15, #16, #17, #20, #21, #26, #32, #34, #38, #39, #41, #42, #43, #44, #48, #50, #51, #52, #53, #54, #55, #57, #58, #214) the facility identified as having signed an arbitration agreement. The facility census was 64. Findings include: 1. Review of the medical record for Resident #214 revealed an admitted [DATE]. Diagnoses included type two diabetes, obstructive sleep apnea, respiratory failure, morbid obesity, generalized anxiety disorder, chronic obstructive pulmonary disease (COPD), and major depressive disorder. Resident #214 was her own resident representative. Review of Resident #214's admission Minimum Data Set (MDS) 3.0 assessment, dated 04/01/25, revealed the resident had adequate hearing, was able to make herself understood, was able to express ideas and wants, had clear comprehension, adequate vision, and was cognitively intact. Review of the facilities arbitration agreement titled Agreement to Arbitrate Disputes located in the Resident #214's admission packet revealed arbitration was a private process where disputing parties would agree that one or several individuals could decide a dispute, between the resident and the facility, after receiving evidence and hearing arguments, rather than a judge or jury deciding in a court of law. Instead of a judge or jury, arbitration involved one or more arbitrators who were usually attorneys or other professionals. The arbitration agreement was a legally binding agreement, could be enforced by a court of law, and could only be appealed on very narrow grounds. The resident had the right to rescind the arbitration agreement within 30 days of signing the agreement. The arbitration agreement had been signed by Resident #214, with an electronic signature, on 04/22/25. Interview on 04/22/25 at 3:50 P.M. with Resident #214 revealed after the resident had reviewed her signed arbitration agreement, dated 04/22/25 (the same day of the interview), the resident stated she didn't know what an arbitration agreement was. She went on to state that if something were to happen to her, she would like to pursue a lawyer in the court of law, and if she understood what she was signing, she would not have agreed to the arbitration agreement. 2. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, essential hypertension (high blood pressure), gastroesophageal reflux disease (GERD), bipolar disorder, and anxiety disorder. Resident #26 was his own responsible party. Review of Resident #26's quarterly MDS 3.0 assessment revealed the resident had adequate hearing, was able to express ideas and wants, had clear comprehension, adequate vision, and was cognitively intact. (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities arbitration agreement titled Agreement to Arbitrate Disputes located in the Resident #26's admission packet revealed arbitration was a private process where disputing parties would agree that one or several individuals could decide a dispute, between the resident and the facility, after receiving evidence and hearing arguments, rather than a judge or jury deciding in a court of law. Instead of a judge or jury, arbitration involved one or more arbitrators who were usually attorneys or other professionals. The arbitration agreement was a legally binding agreement, could be enforced by a court of law, and could only be appealed on very narrow grounds. The resident had the right to rescind the arbitration agreement within 30 days of signing the agreement. The arbitration agreement had been signed by Resident #26 on 01/22/25. Interview on 04/16/25 at 9:04 A.M. with Resident #26 revealed when asked what his understanding of the arbitration process was when a dispute arose between the facility and the resident, the resident replied I don't know what that is. When asked if there was anything he would have liked to have known prior to signing the arbitration agreement, the resident replied I wish I knew what it was. When asked if the arbitration agreement had been explained in a way the resident understood, the resident replied, I don't even know what it is. 3. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included acute kidney failure, chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), major depressive disorder, and anxiety disorder. Resident #51 was his own resident representative. Review of Resident #51's quarterly MDS 3.0 assessment, dated 04/06/25, revealed the resident had adequate hearing, the ability to express wants and needs, clear comprehension, adequate vision, and was moderately impaired cognitively. Review of the facilities arbitration agreement titled Agreement to Arbitrate Disputes located in the Resident #51's admission packet revealed arbitration was a private process where disputing parties would agree that one or several individuals could decide a dispute, between the resident and the facility, after receiving evidence and hearing arguments, rather than a judge or jury deciding in a court of law. Instead of a judge or jury, arbitration involved one or more arbitrators who were usually attorneys or other professionals. The arbitration agreement was a legally binding agreement, could be enforced by a court of law, and could only be appealed on very narrow grounds. The resident had the right to rescind the arbitration agreement within 30 days of signing the agreement. The arbitration agreement had been signed by Resident #51 on 01/21/25. Interview on 04/16/25 at 9:18 A.M. with Resident #51 revealed when asked what his understanding of the arbitration process was when a dispute arose, he stated I don't know what it is. I never heard of it. When asked if the arbitration agreement was explained in a way that he understood, Resident #51 replied I don't know what it is. 4. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included morbid obesity, dependence on supplemental oxygen, bipolar disorder, schizoaffective disorder, atherosclerotic heart disease, and anxiety disorder. Resident #20 was his own responsible party. Review of Resident #20's quarterly MDS assessment, dated 03/14/25, revealed the resident had adequate hearing, the ability to express ideas and wants, clear comprehension, adequate vision, and was cognitively intact. (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities arbitration agreement titled Agreement to Arbitrate Disputes located in the Resident #20's admission packet revealed arbitration was a private process where disputing parties would agree that one or several individuals could decide a dispute, between the resident and the facility, after receiving evidence and hearing arguments, rather than a judge or jury deciding in a court of law. Instead of a judge or jury, arbitration involved one or more arbitrators who were usually attorneys or other professionals. The arbitration agreement was a legally binding agreement, could be enforced by a court of law, and could only be appealed on very narrow grounds. The resident had the right to rescind the arbitration agreement within 30 days of signing the agreement. The arbitration agreement had been signed by Resident #20, with an electronic signature, on 07/19/23. Interview on 04/16/25 at 9:09 A.M. with Resident #20 revealed when asked what his understanding of the arbitration was when a dispute arose between the facility and the resident, the resident stated, I don't know. He stated he did not understand that he had given up his right to litigation in a court proceeding. When asked if he felt he was obligated, required, forced, or pressures to sign the binding agreement, the resident replied they just said 'sign, sign, sign'. I wouldn't have signed something like that. 5. Review of medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), obesity, and a history of pulmonary embolism (a blood clot in the lungs with shortness of breath being a common symptom). Resident #21 was her own responsible party. Review of Resident #21's quarterly MDS 3.0 assessment, dated 03/13/25, revealed the resident had adequate hearing, was able to express ideas and wants, had clear comprehension and adequate vision, and was cognitively intact. Review of the facilities arbitration agreement titled Agreement to Arbitrate Disputes located in the Resident #21's admission packet revealed arbitration was a private process where disputing parties would agree that one or several individuals could decide a dispute, between the resident and the facility, after receiving evidence and hearing arguments, rather than a judge or jury deciding in a court of law. Instead of a judge or jury, arbitration involved one or more arbitrators who were usually attorneys or other professionals. The arbitration agreement was a legally binding agreement, could be enforced by a court of law, and could only be appealed on very narrow grounds. The resident had the right to rescind the arbitration agreement within 30 days of signing the agreement. The arbitration agreement had been signed by Resident #21, with an electronic signature, on 12/04/23. Interview on 04/16/25 at 11:38 A.M. with Resident #21 revealed when asked what her understanding of the arbitration process was when a dispute arose between the facility and the resident, the resident replied, I don't know what that is. When asked if she understood that she was giving up the right to litigation in a court proceeding, she replied she didn't understand. When asked if there was anything she would have liked the facility to explain better in regard to the arbitration agreement, she stated she would have liked for them to have explained the arbitration agreement better. (continued on next page)		

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

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/22/25 at 11:49 A.M. with Mobile Admission Director (MAD) #604 revealed the Administrator and herself were completing admission agreements with the residents, however, she was currently completing most of the admission agreements. She stated the facility was in the process of hiring an admissions director for the facility. She stated the arbitration agreement conversation would take place when the admission agreement was being signed. When explaining the arbitration agreement with the residents, she stated she would ask the residents if they understood the concept of arbitration and would explain how an arbitration agreement worked in the long term setting. She stated she would go back within the conversation and ask the residents if they understood the arbitration process but didn't document if they understood the arbitration agreement. She stated she did not go back to ask the residents who have signed an arbitration agreement if they still understood the arbitration agreement within the 30 days of signing the arbitration agreement, which would give the resident time to rescind the agreement. MAD #604 revealed it didn't surprise her that the residents were stating they didn't understand the arbitration agreement since most folks don't pay attention to what they are signing in general. Review of facility policy titled Resident Admission Policy, revised 10/05/20, revealed the Admissions Director or Manager on Duty or designee would meet with resident/resident representative to complete and all admission paperwork, within 48 hours of the resident's admission and all questions regarding residency, services and rates for services would be answered prior to or before completion of signing the admission agreement, which included the arbitration agreement.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, review of the facility policies, and review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to maintain infection control practices by not adhering to proper hand hygiene during care for two residents (#21 and #22). This affected two residents (#21 and #22) of five residents reviewed for assistance with activity of daily living. Also, the facility failed to ensure a flow diagram and a written description to describe the facility's water system was included in the facility water management program (WMP) in order to minimize the growth and transmission of the bacterium Legionella. This had the potential to affect all residents residing at the facility. The facility census was 64. 1. Record review for Resident #21 revealed an admitted [DATE] with diagnoses including obesity, muscle weakness and the need for assistance with personal care. An observation was conducted on 04/23/25 at 11:06 A.M. of Certified Nursing Assistant (CNA) #524 and #574 completing incontinence care for Resident #21. Resident #21's sheet and bath blanket underneath Resident #21 was saturated with urine and the blanket over her body was wet with urine. CNA #524 placed the saturated items in a disposable bag with her gloved hands. CNA #524 completed the incontinence care for Resident #21 and without changing her contaminated gloves or washing her hands after incontinence care picked up clean blankets and placed the blankets on Resident #21. CNA #524 proceeded to reposition Resident #21, opened the door, removed the glove on her right hand, left the room with the bag of soiled linen, walked down the hall to the soiled utility room, opened that door using her soiled hand, then disposed of the soiled linen into a container. CNA #524 then returned to Resident #21's room to wash her hands. CNA #524 confirmed she did not wash her hands or use hand sanitizer after providing incontinence care or before leaving Resident #21's room and touching the entrance door to the soiled utility room. CNA #524 confirmed the findings at the time of the observation. Interview on 04/23/25 at 11:27 A.M. with the Director of Nursing (DON) revealed each staff member should wash their hands after touching a resident or soiled items prior to leaving the residents room. Review of the facility policy titled, Standard Precautions dated 03/15/16 revealed practicing hand hygiene is a simple but effective way to prevent the spread of infections by breaking the chain of infection. Proper cleaning of hands can prevent the spread of germs, including those that are resistant to antibiotics and are becoming resistant to antibiotics. Examples of when to perform hand hygiene include before and after direct contact with a residents intact skin, after contact with inanimate objects, after hands move from a contaminated body site to a clean body site (example peri care) and after removing gloves. 44808 2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including severe protein-calorie malnutrition, dementia with psychotic disturbance, adult failure to thrive, muscle wasting and atrophy, and cognitive communication deficit. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/02/25, indicated Resident #22 had a severe cognitive impairment and required set-up or clean-up assistance for eating meals. On 04/17/25 at 8:20 A.M., an observation of the dining room revealed Certified Nursing Assistant (CNA) #551 entered the dining room, sat down beside Resident #22, and began providing feeding assistance to Resident #22. CNA #551 did not wash her hands after entering the dining room or before providing feeding assistance for Resident #22. On 04/17/25 at 8:24 A.M., an interview with CNA #551 confirmed she entered the dining room and did not wash her hands prior to providing feeding assistance for Resident #22. 46195 3. Review of the facility Water Management Program (WMP) for Legionella (the bacteria that causes Legionnaire's disease which results in a serious type of pneumonia). revealed there was no flow diagram or text description to identify the buildings water system and all locations in the water system where Legionella could potentially grow and spread . An interview on 04/15/25 at 1:39 P.M. with the Director of Plant Maintenance (DPM) #516 confirmed he had not developed a Legionella diagram assessment for the building or a text description of the facility's water system. DPM #516 stated he was flushing water fixtures which had not been used for 14 days or later to help prevent Legionnaire's disease. When asked why a flow diagram or text description had not been developed, DPM #516 stated he had been busy with everything else on the campus and hadn't had time to complete it. DPM #516 verified he had no evidence that all critical control points in the building were being monitored to prevent growth and spread of Legionella. Review of the undated facility policy titled Legionella or Legionnaire's Disease revealed Legionnaire's Disease also called Legionella Pneumonia is a rare but very serious type of pneumonia caused by the bacterium Legionella which is found naturally in fresh water environments including lakes and streams. Legionella becomes a health problem when it grows and spreads in human-made water systems including showers, faucets, unflushed eye washed stations, cooling towers for air conditioners, hot tubs, decorative fountains, hot water tanks and large plumbing systems. Surveillance for Legionella includes monitoring for appropriate levels of disinfectants in public and facility water systems. Monitoring the environment included maintenance performing routine water monitoring services, flushing eye wash stations, emergency potable water is secured and chlorination levels monitored, housekeeping maintains proper cleaning of ice machines, and reduce risk of growth by maintaining water temperatures in range. The policy did not address the need to describe the facility's water systems using flow diagrams and a text description. Review of the Centers for Disease Control and Prevention website located at https://www.cdc.gov/control-legionella/php/wmp/wmp-steps.html revealed WMPs identified hazardous conditions, and one of the steps to minimize the health impact of waterborne pathogens was describing the buildings water systems using flow diagrams and a written/text description to describe the building's water systems.		

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 46195 Based on observation, interview, and review of facility policy, the facility failed to ensure all residents at all times on the secured unit were able to communicate their needs using a call system that would relay an audible sound directly to a staff member or to a centralized staff work area on the secured unit. This had the potential to affect all 13 residents (#3, #8, #10, #18, #29, #30, #49, #50, #55, #56, #57, #58, and #61) living on the secured unit. The facility census was 64. Findings include: Observations during an environmental tour on 04/15/25 between 2:02 P.M. and 4:24 P.M. with Director of Plant Maintenance (DPM) #516 revealed when a call light was pressed in Residents #8 and #58's room on the secure unit, the light outside the room lit up but there was no audible sound coming from the call system unit at the nurse's station. Licensed Practical Nurse (LPN) #503, who was sitting at the nurse's station where the call system unit was sitting on the counter, confirmed the light outside the room had come on but she heard no audible sound coming from the call system unit. LPN #503 stated the reason why there was no sound coming from the call system was because the volume on the unit had been turned down. Once LPN #503 turned up the volume on the call system unit, there was an audible sound coming out of the system when a call light was activated. LPN #503 verified if the volume was turned down, any of the resident call lights on the unit would not audibly notify staff the call light was activated. Interview on 04/15/25 at 2:57 P.M. with DPM #516 revealed he had noticed on other occasions the call system units had the sound turned off or way down so it could not be heard on the unit by staff. Review of undated facility policy titled Resident Rights revealed residents had the right to have a method to communicate needs to staff. This deficiency represents non-compliance investigated under Complaint Number OH00164146		