STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366104	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem North Healthcare Center	250 Continental 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on closed medical record review, policy review and interview, the facility failed to timely notify Resident #70's representative of an acute change in condition. This affected one resident (#70) of 12 residents reviewed for notification of change. Findings include: Review of the closed medical record for Resident #70 revealed the resident was admitted to the facility on [DATE] with diagnoses of Temefactive Multiple Sclerosis (MS), Type 1 diabetes, autistic disorder, attention-deficit hyperactivity, narcolepsy, anxiety disorder, transient alteration of awareness, other symptoms involving cognitive functions and awareness and aphasia. Resident #70 was discharged to the hospital on 09/07/24. Review of the Nursing Admission Evaluation assessment dated [DATE] revealed Resident #70 arrived at the facility on 08/30/24 at 12:29 P.M. with an admitting diagnosis of MS, was confused/disoriented and had a gastrostomy tube with a nocturnal enteral feeding. Resident #70 was assessed as being severely cognitively impaired. Review of the nurse's note dated 09/06/24 timed 9:26 P.M. authored by Registered Nurse (RN) #3 revealed at 6:00 P.M., Resident #70 was cool and clammy, restless as in tossing head back and forth on pillow, tremors note to all extremities. Vital signs: 97.7 Fahrenheit (F), 124 pulse (normal pulse 60 to 100), 24 respirations (normal respirations 18), 148/104 blood pressure (normal blood pressure 120/80) , 324 blood sugar. When asked if she was experiencing pain, resident said, yes. Medicated with Tylenol as needed order at 6:30 P.M. Updated Certified Nurse Practitioner (CNP) #2 on change in status. New order received for Norco 5-325 by mouth every six hours as needed. Resident was observed lying in bed at present time, no tremors. Respirations were quiet and even, skin cool and dry. The nurse's note was silent to Resident #70's mother/resident representative notified of the change in condition. Interview on 10/07/24 at 12:50 P.M. with Resident #70's mother/resident revealed she was unaware of Resident #70 having tremors, being cool and clammy and tossing her head back and forth on the pillow during the evening of 09/06/24. Interview on 10/07/24 at 1:00 P.M. with RN #3 verified she did not notify Resident #70's representative of the resident's change in condition during the evening of 09/06/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Salem North Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Continental 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/08/24 at 11:35 A.M. with Regional Director of Clinical Operations (RDCO) #7 verified Resident #70's family should have been notified of Resident #70's change in condition (tremors and abnormal vital signs) on 09/06/24. Review of the facility's undated Notification of Change in Condition policy revealed the center must inform the resident, consult with the resident's physician and/or notify the resident's representative, authorized family member, or legal power of attorney/guardian when there was a change requiring such notification. Circumstances requiring notification included but were not limited to: a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status including but not limited to: clinical complications. This deficiency represents non-compliance investigated under Complaint Number OH00157701.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on closed medical record review, review of telehealth progress notes, Life flight progress notes, policy review, and interviews, the facility failed to provide adequate and necessary care to meet the total care needs of Resident #70. The facility failed to consistently monitor blood (sugar) glucose levels as ordered, failed to administer insulin as ordered and failed to monitor Resident #70, who was assessed as being severely cognitively impaired and dependent on staff for activities of daily living, after an acute/significant change in condition. This resulted in Immediate Jeopardy and actual harm with the potential for serious impairment and/or death beginning on [DATE] at 4:18 P.M. when Resident #70's blood glucose level was elevated at 517 milligram/deciliter [mg/dl] (normal-,d+[DATE] mg/dl). Insulin was administered per physician order, however no additional assessment or monitoring was documented as being completed. At 6:00 P.M., Resident #70 was assessed to be clammy and having tremors with abnormal vital signs. Resident #70's blood sugar was 324 with no intervention/insulin administered at that time. At 8:00 P.M., Resident #70's blood sugar was 274 with no additional assessment of the resident's condition at that time. On [DATE] at 5:00 A.M., no blood sugar monitoring was completed as ordered and there was no evidence Resident #70 was assessed. On [DATE] at 9:40 A.M. Resident #70's blood sugar was checked and registered high on the facility glucometer. The physician was notified and an order for additional insulin was obtained; however, no additional assessment or monitoring of the resident was completed. At 10:55 A.M., Resident #70's blood sugar was rechecked and remained high. Resident #70's vital signs were abnormal (the resident was hyperglycemic, tachycardic, diaphoretic, and unresponsive), and she was transferred to the local hospital. Upon arrival at the local hospital, it was determined Resident #70 was in diabetic ketoacidosis (life threatening complication of diabetes mellitus), had severe hypernatremia (high sodium levels indicative of dehydration) and was in septic shock (widespread infection causing organ failure and dangerously low blood pressure). Resident #70's body temperature had risen to 105.6 degrees Fahrenheit (F). Resident #70 was assessed to require emergent transport to a regional hospital. Resident #70 was subsequently airlifted to a regional hospital where she was admitted to the intensive care unit (ICU) for continued stabilization and treatment. A concern that did not rise to an Immediate Jeopardy was identified when the facility failed to ensure adequate diabetic care and monitoring (including the administration of insulin) was provided for Resident #71 and Resident #2. This affected three residents (#2, #70 and #71) of 12 residents reviewed for a change in condition. On [DATE] at 5:27 P.M., the Interim Administrator, Regional Director of Clinical Operations (RDCO) #7 and Assistant Director of Nursing (ADON) #1 were notified Immediate Jeopardy began on [DATE] when Resident #70 was noted to have an acute change in condition with lack of evidence of timely and necessary monitoring and intervention/treatment. On [DATE] at 11:04 A.M. Resident #70 was noted to be tachycardic and unresponsive with an elevated blood sugar over 500 mg/dl requiring an emergent transfer to the hospital. The resident was subsequently transferred to the local hospital and was diagnosed with diabetic ketoacidosis (due to elevated blood sugar), severe hypernatremia and septic shock. While at the hospital, her body temperature continued to rise to 105.6 degrees F when the decision was made to intubate (placement of a tube into the trachea to keep the airway open) and Life Flight her to a larger hospital where she was admitted to the ICU. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Salem North Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Continental 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions. On [DATE] at 11:04 A.M. 911 was called and Resident #70 was subsequently transferred to the hospital for medical intervention due to an acute/significant change in condition. The resident did not return to the facility. On [DATE] at 6:00 P.M. Medical Director #20 was notified of the State agency concerns related to Resident #70. On [DATE] between 6:00 P.M. and 7:00 P.M., all licensed nurses were educated by ADON #1 and Registered Nurse (RN) #21 on the facility ' s policy of Notification of Change in Condition with emphasis on timely identification, ongoing monitoring and interventions provided to treat the change in condition. On [DATE] between 6:00 P.M. and 7:00 P.M., all licensed nurses were educated by ADON #1 and RN #21 on the facility policy identified as, Physician Orders with emphasis on medication administration of insulin and monitoring of blood glucose levels. On [DATE] at 6:30 P.M., ADON #1 educated Licensed Practical Nurse (LPN) #4 (the nurse identified to be involved with Resident #70 ' s care) on how to contact Information Technology (IT) (for computer issues), physician orders, notification of change in condition, clinical documentation standards, blood glucose monitoring, and managing diabetic change in condition. On [DATE] at 7:00 P.M., the Director of Nursing (DON)/designee audited the last 14 days of residents who had physician orders for insulin administration. Any resident found to have an omission of insulin administration had their physician and family notified. All concerns were addressed, and new orders were transcribed immediately. On [DATE] at 9:00 P.M., the DON/designee, RDCO #7 and ADON #1 audited the last 14 days of residents who had physician orders for blood glucose monitoring and/or antidiabetic medications. Any resident found to have a blood glucose outside their parameters and not with the appropriate follow up had their physician and family notified. All concerns were addressed, and new orders were transcribed immediately. On [DATE] at 10:00 P.M., the DON/designee audited the last 14 days of residents ' progress notes for a change in condition. Any resident identified with a change in condition and found not to have interventions provided had their physician and family notified. All concerns were addressed, and new orders were transcribed immediately. On [DATE] at 6:00 A.M., ADON #1 re-educated LPN #4 in person on how to contact IT, physician orders, notification of change in condition, clinical documentation standards, blood glucose monitoring, and managing diabetic change in condition. On [DATE] at 2:45 P.M., an Ad Hoc Quality Assurance Performance (QAPI) meeting was held with the Interim Administrator, DON, RDCO #7, ADON #1, RN #21 and Medical Director #20 to discuss the concerns involving Resident #70 and a facility corrective action plan. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], LPN #4 received a final written warning corrective action for performance/policy violation related to medication administration, notification of change in condition, and resident monitoring. Failure to document and monitor resident in change in condition. Beginning on [DATE] the DON/designee would audit for change in condition by reviewing the progress notes in the daily clinical meeting. This would be an ongoing process. Beginning on [DATE] the DON/designee would complete an audit for missed/omitted insulin/antidiabetic medications and blood glucose monitoring in the daily clinical meeting. This would be an ongoing process. Beginning on [DATE] the DON/designee would begin audits on nurses completing blood glucose checks, administering insulin as needed, and documenting the process by observing three nurses weekly for four weeks then randomly thereafter. The Administrator and DON would continue to monitor compliance in the monthly QAPI meetings for three months then as needed for one year. RDCO #7 would continue to monitor compliance during monthly visits for three months then on an as needed basis. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action and monitoring for effectiveness and on-going compliance. Findings include: 1. Review of the closed medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses including Temefactive Multiple Sclerosis (MS), Type 1 diabetes mellitus, autistic disorder, attention-deficit hyperactivity, narcolepsy, anxiety disorder, transient alteration of awareness, other symptoms involving cognitive functions and awareness, and aphasia. Resident #70 and was discharged to the hospital on [DATE]. Review of the Nursing Admission Evaluation assessment dated [DATE] revealed Resident #70 arrived at the facility on [DATE] at 12:29 P.M. with an admitting diagnosis of MS, was confused/disoriented and had a gastrostomy tube with a nocturnal enteral feeding. Resident #70 was assessed as being severely cognitively impaired. Review of the hyperglycemia care plan dated [DATE] revealed Resident #70 was admitted with Type 1 diabetes with hyperglycemia with history of long-term insulin dependence. Resident #70 had utilized an insulin pump, however had lost the insulin pump. Interventions included administer insulin injections per orders; administer medications per medical provider's orders; report abnormal findings to medical provider and resident/resident representative; observe for signs and symptoms of hyperglycemia including increased thirst, fatigue, frequent urination, dry skin, muscle cramps, abdominal pain, kussmual (deep rapid and labored) breathing, acetone breath, stupor, and obtain blood sugars per order. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the MS care plan dated [DATE] revealed Resident #70 was admitted with newly diagnosed MS with spastic hemiplegia with lesions. Interventions included monitor vital signs as needed and report abnormal findings to medical provider and resident/resident representative. Review of the physician orders from [DATE] revealed Resident #70 was ordered Insulin Glargine-yfgn (a long-acting insulin) subcutaneous solution pen-injector 100 unit/milliliters (ml) inject 10 units subcutaneously two times a day for diabetes scheduled in the morning between 7:00 A.M. and 10:00 A.M. and at bedtime between 9:00 P.M. and 10:00 P.M.; the order was entered on [DATE] at 9:52 P.M. into the electronic medical record (EMR). Additionally, Resident #70 was ordered Insulin Lispro [NAME] Kwikpen (a short-acting insulin) solution pen-injector 100/ml inject as per sliding scale: notify physician if [blood sugar] less than 70, if 150 - 200 give two units; 201 - 250 give four units; 251 - 300 give six units; 301 - 350 give eight units; 351 - 400 give 10 units; notify physician if greater than 401, subcutaneously four times a day for diabetes; the order began on [DATE] at 3:50 P.M. In addition, Resident #70 was also ordered Prednisone (a steroid) oral tablet 40 milligrams in the morning via feeding tube for MS. (Steroid medications can raise the glucose levels of residents with diabetes). Review of the nursing note dated [DATE] timed 5:39 A.M. revealed Resident #70's blood sugar was 545 mg/dl, the physician was notified. The note further indicated the nurse was looking through hospital paperwork. Resident #70 was on Lispro (a short-acting insulin) in hospital with last dose being given on [DATE]. Discharge orders were only for Lantus (a long-acting insulin) 10 units twice a day. The physician gave one time order for eight units of Lispro. The note indicated that the nurse would continue to monitor. Review of the [DATE] Medication Administration Record (MAR) revealed on [DATE] Resident #70's blood sugar was not obtained, and the long-acting insulin (Insulin Glargine-yfgn) was not administered as ordered. On [DATE] at 8:00 P.M. Resident #70 ' s blood sugar was not obtained as ordered to determine if the sliding scale dosage of short acting insulin (Insulin Lispro [NAME] Kwikpen) was needed, and on [DATE] at bedtime Resident #70's blood sugar was not checked to see if the sliding scale dosage of short acting insulin was needed and the ordered long-acting insulin was not administered. Review of the nurse's notes and nursing assessments in the hard chart and electronic medical record (EMR) from [DATE] to [DATE] revealed there was no corresponding documentation to support the resident's blood sugar was taken and if insulin was administered on [DATE] at bedtime for long-acting insulin and on [DATE] at 8:00 A.M. and bedtime for the short-acting or the long-acting insulin. Review of the nurse's note dated [DATE] timed 9:05 A.M. revealed a late entry admission nurse note indicating Resident #70 was admitted to the facility on Friday, [DATE] at 1:00 P.M. Review of the Medication Administration Record (MAR) from [DATE] revealed Resident #70 ' s blood sugar was not obtained, and insulin was not administered on the following six dates and times: On [DATE] at 4:30 P.M. short-acting insulin On [DATE] at 8:00 P.M. bedtime for short-acting and long-acting insulin On [DATE] at 5:00 A.M. short-acting insulin (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:00 A.M. short-acting insulin On [DATE] at 8:00 P.M. and bedtime short-acting and long-acting insulin On [DATE] at 5:00 A.M. short-acting insulin Review of the eMAR - Medication Administration Note for Insulin Glargine-yfgn dated [DATE] timed 12:42 P. M. and 12:57 P.M. revealed blood sugar high, telehealth notified, additional insulin administered as ordered. Record review revealed no additional assessment of the resident's overall condition at this time related to the incident of hyperglycemia (elevated blood sugar). Review of the Telehealth physician progress note dated [DATE] timed 1:08 P.M. revealed blood sugar reading high, give additional 10 unites now, recheck in 30 minutes, call if remains above 400 mg/dl. Review of the nurse's notes, nursing assessments and weights/vital signs tab in the EMR from [DATE] revealed there was no evidence Resident #70's blood sugar was rechecked in 30 minutes. Review of Certified Nurse Practitioner (CNP) #2's progress note dated [DATE] revealed Resident #70 had been admitted to the facility on [DATE] from acute rehabilitation following a prolonged inpatient hospitalization for recently diagnosed MS with a presentation of aphasia, right hemiparesis and new demyelinating lesions on MRI. Review of systems was unable to be obtained due to aphasia, responses were limited to yes or no answers and resident did not follow commands. Type 1 diabetes with very poor glycemic control, most recent HbA1C (a blood test that measures a person's average blood sugar level over the past two to three months) was 10.1 percent (normal range below 5.7 percent) with a plan to continue basal insulin glargine 10 units twice a day, continue sliding scale insulin, continue to monitor blood glucose levels closely and hold nocturnal feedings as resident was eating 75 percent to 100 percent of all meals therefore, at this point, would not add more insulin. Review of the nurse's notes and nursing assessments in the hard chart and EMR from [DATE] to [DATE] revealed there were no corresponding evidence to show if the blood sugar was taken and if the short acting insulin was administered on [DATE] at 4:30 P.M., on [DATE] at 8:00 P.M. and bedtime for the short-acting and long-acting insulin, on [DATE] at 5:00 A.M. for the short-acting insulin, on [DATE] at 5:00 A.M. for short-acting insulin, on [DATE] at 8:00 P.M. and bedtime for the short-acting and long-acting insulin, and on [DATE] at 5:00 A.M. for the short-acting insulin. In addition, review of the eMAR - Medication Administration Note for Insulin Lispro dated [DATE] timed 12:53 P.M. revealed blood sugar read high, administered 14 units as ordered by the nurse practitioner after notification. Review of the eMAR - Medication Administration Note for Insulin Lispro dated [DATE] timed 4:18 P.M. authored by RN #3 revealed nurse practitioner notified, and order received to give 14 units of Humalog (short-acting insulin) now. Record review revealed no additional assessment of the resident's overall condition at this time related to the incidents of hyperglycemia (elevated blood sugar) noted on [DATE]. Review of the Amount Eaten documentation for Resident #70 revealed Resident #70 refused dinner on [DATE]. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nurse's note dated [DATE] timed 9:26 P.M. authored by RN #3 revealed at 6:00 P.M., Resident #70 was cool and clammy, restless as in tossing head back and forth on pillow, tremors noted to all extremities. Vital signs included temperature 97.7 degrees F, pulse 124 pulse (normal 60 to 100), respirations 24 (elevated), blood pressure ,d+[DATE] (normal blood pressure ,d+[DATE]), and blood sugar 324 mg/dl. When asked if she was experiencing pain, resident indicated, yes. Medicated with Tylenol which was ordered as needed at 6:30 P.M. Updated CNP #2 on change in status. New order received for Norco , d+[DATE] (opioid pain reliever) by mouth every six hours as needed. Resident #70 was observed lying in bed at present time without tremors. Respirations were quiet and even, skin cool and dry. Review of the Skilled Documentation assessment dated [DATE] timed 8:12 A.M. authored by ADON #1 revealed the assessment incorrectly indicated Resident #70 did not have any insulin changes in the last 24 hours. There was no evidence Resident #70's vital signs were monitored, or the resident was correctly comprehensively assessed. Review of the nurse's notes, nurse's assessments, MAR from [DATE] and weights/vitals tab in the EMR revealed there was no evidence Resident #70's vital signs were monitored, or the resident was comprehensively assessed after 6:00 P.M. on [DATE] until [DATE] at 9:31 A.M. Review of the Telehealth Physician #17 progress note dated [DATE] timed 9:31 A.M. revealed the nurse called because Resident #70's blood sugar reading high, Orders were given to administer 15 units of insulin, recheck blood sugar in one hour and call if above 400 mg/dl. Review of the nurse's note dated [DATE] timed 9:40 A.M. authored by RN #6 revealed Resident #70's blood sugar read high. Telehealth was called and administered 15 units of insulin Lispro as ordered. Review of the Telehealth CNP #18 progress note dated [DATE] timed 10:53 A.M. revealed hyperglycemia high. Resident #70 received 15 units of Lispro earlier, still reading high. The note reflected the resident was on a high dose of Prednisone. Orders given to administer 10 units of Lispro now and recheck in one hour and call back if still over 400 mg/dl. Vital signs were taken with a blood pressure of ,d+[DATE]. Review of the nurse's note dated [DATE] timed 10:55 A.M. authored by RN #6 revealed Resident #70 ' s blood sugar rechecked and still read high. Contacted Telehealth. Order given for 10 units of insulin Lispro. Review of the Telehealth CNP #19 progress note dated [DATE] timed 11:07 A.M. revealed the note indicated it was okay to send the resident to the emergency room due to unresponsiveness. Review of the nurse's note dated [DATE] timed 11:20 A.M. authored by RN #6 revealed order was received for Resident #70 to be transferred out to the emergency room after contacting Telehealth. The family was notified, and the resident was transferred to the emergency room . Vital signs included the resident's blood pressure was ,d+[DATE] (low), pulse 126 (high), respirations 16 and temperature was 98.2 degrees F. Review of the nurse's note dated [DATE] timed 4:23 P.M. revealed received a call from the nurse at hospital stating, the resident was being life flighted to another hospital with diagnoses of diabetic ketoacidosis (DKA), septic shock and hypernatremia. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNP #2's progress note dated [DATE] timed 5:59 P.M. revealed on [DATE] at 11:04 A.M., the nurse notified her by phone Resident #70 was tachycardic to the 140's, diaphoretic, unresponsive with myoclonus (sudden involuntary muscle spasms) and blood glucose reading high. Order given to send resident to the emergency room . Review of the Minimum Data Set (MDS) 3.0 Discharge - Return Not Anticipated assessment dated [DATE] revealed Resident #70 had short term memory problems, was moderately impaired for daily decision making, and needed partial/moderate assistance with transfers from the bed to the chair, needed substantial/maximal assistance for eating, oral hygiene, bathing, and personal hygiene and was totally dependent on staff with toileting, lower body dressing and putting on and taking off footwear. Review of the emergency department physician note dated [DATE] revealed patient [Resident #70] was a type 1 diabetic with poor control with a history of MS who presented via emergency medical services (EMS) for altered mental status and high blood sugar. Facility reported that today she was only responsive to pain and her blood sugar read high on the meter. EMS reported they were unable to get a blood pressure and route. Resident with altered mental status with history and exam consistent with sepsis unclear source in the setting of diabetic ketoacidosis (DKA). The resident was placed on 15 liters non-rebreather due to her skin mottling although she was not in any respiratory distress. Intraosseous (IO) was placed and fluid resuscitation was initiated. Initial cardiac rhythm on monitor was 180 narrow complex tachycardia; patient was hypotensive. Per Advanced Cardiovascular Life Support (ACLS) protocol, she was given six milligrams of adenosine without improvement followed by 12 milligrams of adenosine while attempting to obtain an EKG. No improvement in heart rate. EKG was obtained and rhythm was revealed to be a sinus tachycardia. Continued volume resuscitation. Skin mottling improved. Mental status began to improve and her eyes would flutter open upon saying her name. Heart rate improved from 180's to 130's with fluid resuscitation and blood pressures improved from the 80's to the 100's systolic after two liters of fluid. Foley catheter placed. After three liters of fluid, the resident had not yet had any urine output. Patient hypernatremic 180 with correction for hyperglycemia and was changed to ,d+[DATE] normal saline. Hyperkalemia and hyperglycemia so insulin glucose tolerance test initiated. Rapid drop in insulin so insulin glucose tolerance test was discontinued and dextrose ,d+[DATE] normal saline was initiated. Patient was felt to have symptoms concerning for potential infection based on heart rate greater than 170, blood pressure less than 80 systolic noted at the time of initial triage. Labs were obtained .and were notable for leukocytosis greater than 20 concerning for systemic inflammatory response (SIRS). Based on findings, SIRS criteria and presumed urinary infectious source, the patient was felt to meet criteria for sepsis. The patient had corrected glucose of 166 few hours after initial presentation. This was a significant drop. Concern for rapid correction therefore considered hypertonic saline verse sodium bicarbonate. Patient was given one ampoule of sodium bicarbonate. Repeat point-of-care glucose within normal limits. Temperature went up to 105 F. Discussed case with intensivist at [regional hospital], given worsening temperature and likely neurologic cause of symptoms versus [NAME] hyperthermia, decision was made to intubate the patient and paralyze her. The resident was subsequently transferred to another hospital due to her medical needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER: Salem North Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 250 Continental 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Life Flight CNP's progress note dated [DATE] timed 7:46 P.M. revealed Resident #70 was a resident of a skilled nursing facility (SNF) with baseline mental status that was unclear at the time. On emergency room evaluation today, Resident #70 was found to have glucose over 500 mg/dl. She was initially tachycardic (fast heart rate), hypotensive (low blood pressure) and febrile. Given adenosine (used to convert tachycardia to normal rhythm) with no change. Central line placed and volume resuscitated with three liters of normal saline and two liters of half normal saline for diabetic ketoacidosis and placed on insulin infusion. Resident #70 was also noted to have severe hypernatremia. Insulin infusion stopped after precipitous decline in glucose over one hour (>500 to 178). Ultimately, Resident #70 placed on norepinephrine (used to treat low blood pressure) for blood pressure support. Resident #70 continued to decline, becoming more somnolent and continued with rise in body temperature (temperature maximum of 105.6 F). Resident #70 intubated for airway protection. Given Dantrolene for possible neuroleptic malignant syndrome. At that time, the physician managing Resident #70 requested transfer to a larger hospital for tertiary and/or quaternary services unavailable at the referring facility. Resident #70's condition at time of exam was documented as acutely ill and critically ill. Air medical transport was requested to reduce the out-of-hospital time (22 minutes by air vs approximately 83 minutes by ground) and Resident #70's condition required emergent procedure or evaluation not available at the referring facility. Interview on [DATE] at 11:05 A.M. with CNP #2 revealed on [DATE], CNP #2 was notified Resident #70's blood sugar was greater than 500 mg/dl and CNP #2 ordered sliding scale insulin (short-acting insulin). On [DATE], CNP #2 assessed Resident #70 who was only able to provide yes/no answers and did not appropriately answer. On [DATE], CNP #2 assessed Resident #70 again who was still having hyperglycemia, so CNP #2 ordered to increase long-acting insulin to 14 units twice a day. On [DATE] at 6:22 P.M., RN #3 sent CNP #2 a text message that Resident #70 was agitated, cold and clammy, tremoring and the nurse aides were telling RN #3 that was unusual for Resident #70. RN #3 thought the resident was in pain so CNP #2 advised RN #3 to try Tylenol and CNP #2 would call in an order for Norco. CNP #2 stated she did not hear any more about Resident #70 the rest of the evening and night, so CNP #2 thought everything was fine. On [DATE] at 11:04 A.M., ADON #1 called CNP #2 saying Resident #70 ' s blood sugar was reading high, she was tachycardic in the 140 ' s, and her eyes rolled back in the back of head. CNP #2 verified Resident #70 ' s blood pressure, pulse and respirations were a little high on the evening of [DATE]. CNP #2 indicated although vital signs were not ordered, the nurses could have continued to monitor Resident #70 ' s vital signs on [DATE] into [DATE] as a nursing intervention. Interview on [DATE] at 11:55 A.M. with RN #3 revealed on [DATE], RN #3 worked from 2:00 P.M. to 6:00 P. M., which was her first time working with Resident #70. The prior nurse had reported to RN #3 the resident was having trouble with elevated blood sugars. RN #3 obtained the resident ' s blood sugar between 4:00 P. M. and 5:00 P.M. and called CNP #2 because the blood sugar was high and obtained orders to administer additional insulin and recheck the blood sugar again. RN #3 rechecked the blood sugar and it had lowered to 274 mg/dl. That evening, the nurse aides reported Resident #70 was not acting the same as she usually did. When the nurse aides were sitting and talking with Resident #70 the resident ' s tremors would cease. RN #3 did not think she rechecked Resident #70 ' s vital signs after texting with CNP #2 on [DATE] at 5:22 P.M. regarding the change in condition. RN #3 stated Resident #70 was thirsty when RN #3 administered the Tylenol to the resident. Resident #70 did not eat her dinner on [DATE] and RN #3 had to hold the cup of water and put the medication on a spoon for Resident #70 that evening. RN #3 stated she notified LPN #4 (the oncoming nurse) that something was going on with Resident #70 and keep an eye on her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Salem North Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Continental Drive Salem, OH 44460	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 12:20 P.M. with RN #6 revealed on [DATE] when RN #6 arrived at the facility, Resident #70 was okay. However, after RN #6 checked her blood sugar and obtained vital signs and called Telehealth services Resident #70 was not okay and was slow to respond so the resident was sent to the hospital. Interview on [DATE] at 12:50 P.M. with Resident #70 ' s mother/resident representative revealed the Resident #70's boyfriend visited with the resident on Tuesday ([DATE]) and they video chatted with Resident #70. During this video chat Resident #70 ' s mother observed Resident #70's lips were cracked, and her skin was dry; it looked like she was dehydrated. On [DATE], Resident #70 was diagnosed with diabetic ketoacidosis and sepsis and was severely dehydrated when she arrived at the hospital, and she had to be intubated and sedated. Resident #70 ' s mother stated Resident #70 spent several weeks in the ICU at the hospital and almost died . Resident #70's mother felt Resident #70 was neglected at the facility. Interview on [DATE] at 3:35 P.M. with State tested Nursing Assistant (STNA) #12 revealed Resident #70 was learning how to eat again and at times, the resident had to be fed and other times, the resident was supervised with eating. At times, a staff member had to hold the beverage cup for her to drink fluids. Resident #70 was incontinent and wore an incontinence brief. Interview on [DATE] at 3:50 P.M. with LPN #5 revealed the staff had to provide mostly all activities of daily living care for Resident #70 and on a couple of occasions, the resident had to be fed her meals. LPN #5 did not remember much from working night shift on [DATE] into [DATE] and she did not remember if Resident #70 ' s blood sugar was obtained but did remember the resident ' s blood sugars were fluctuating. Interview on [DATE] at 3:55 P.M. with LPN #4 revealed Resident #70 was having an extremely hard time with her blood sugars and her blood sugars were through the roof the first couple of days she was at the facility. Resident #70 had to be fed. LPN #4 did not remember anything specific from working night shift on [DATE] into [DATE] other than he was in and out of Resident #70 ' s room and gave her the nighttime medications. Interview on [DATE] at 4:15 P.M. with STNA #15 revealed Resident #70 was able to answer yes/no to questions and had to be dressed and fed meals. At times, Resident #70 was able to pick up her fluid cup and other times, staff had to assist her with fluids. Interview on [DATE] at 11:35 A.M. with RDCO #7 verified there was no evidence Resident #70's blood sugars were checked and/or administered insulin on the following dates and times: on [DATE] at bedtime, on [DATE] at 8:00 P.M. and bedtime, on [DATE] at 4:30 P.M., 8:00 P.M. and bedtime, on [DATE] at 5:00 A.M., on [DATE] at 5:00 A.M., on [DATE] at 8:00 P.M. and bedtime and on [DATE] at 5:00 A.M. RDCO #7 also verified Resident #70 ' s vital signs/overall condition was not monitored from [DATE] at 6:00 P.M. to [DATE] at 9:40 A.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem North Healthcare Center	250 Continental Drive Salem, OH 44460

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow up interview on [DATE] at 2:15 P.M. with RDCO #7 revealed LPN #4 was assigned to care for Resident #70 during eight of the 10 missed blood sugar checks and insulin administrations. LPN #4 wrote a statement dated [DATE] that he did check blood sugars and administered medications on [DATE] into [DATE] from 6:00 P.M. to 6:00 A.M., [DATE] into [DATE] from 6:00 P.M. to 6:00 A.M., [DATE] into [DATE] from 6:00 P.M. to 6:00 A.M. and [DATE] into [DATE] from 6:00 P.M. to 6:00 A.M. However, LPN #4, indicated there was a technical error with the EMR and his documentation was not saved. RCDO #7 revealed there was no IT ticket or nursing progress note(s) to support this claim. RDCO #7 felt it could have been a user error on LPN #4 ' s part. Interview on [DATE] at 9:45 A.M. with ADON #1 revealed ADON #1 was notified Resident #70 was having a change in condition (on 09XXX,d+[DATE]), so ADON #1 came to the facility and went straight to Resident #70 ' s room. Resident #70 was diaphoretic and non-responsive. ADON #1 had already spoken to CNP #2 and obtained an order to send Resident #70 to the emergency department. Review of the facility's undated Bl[TRUNCATED]