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	04/28/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, review of a facility self-reported incident (SRI) and facility policy review, the facility failed to prevent misappropriation of opioid medication. This affected one resident (#32) out of three residents reviewed for misappropriation. The facility census was 63.Findings include:Review of Resident #32's medical record indicated an admission date of 07/30/20 with diagnoses including acute kidney failure, endˆstage renal disease, pleural effusion, hypertensive chronic kidney disease Stage V, diabetes, chronic obstructive pulmonary disease, peripheral vascular disease, atrial flutter, and dependence on renal dialysis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident was cognitively intact, required supervision for eating, needed partial to moderate assistance with oral hygiene, and was dependent on staff for toileting hygiene, showers, dressing, and bed mobility. Review of the resident's care plan showed the resident had, or was at risk for, pain related to chronic conditions including open skin areas, peripheral vascular disease, double aboveˆknee amputations, pleural effusions with a Pleurex drain in place, and diabetic neuropathy. Interventions included providing and evaluating nonˆpharmacological pain measures, completing pain assessments, monitoring for pain each shift, and following physician orders for pain complaints.Review of Resident #32's physician orders date April 2026 revealed the resident was prescribed Oxycodone (opioid pain medication) 5 milligrams (mg) give two tablets every four hours as needed for pain. This medication was discontinued on 04/09/26.Review of the SRI tracking #273271 dated 04/13/26 revealed during the shift change narcotic count completed by Licensed Practical Nurse (LPN) #804 and LPN #801 it was discovered by LPN #801 that Resident #32's card of Oxycodone 5 mg had the pill in slot #2 and slot #6 taped in and were not uniform in color and was not scored like the other pills in the medication card.Review of the witness statements from SRI #273271 revealed LPN #804 stated when she and LPN #801 were counting the narcotics at change of shift, LPN #801 noticed two of the pills in Resident #32's card of Oxycodone 5 mg were taped into slot #2 and #6. The pills taped in were not the same and were smooth with no markings on them. LPN #804 additionally stated LPN #801 called the Director of Nursing (DON) for further instructions. Further review revealed she stated when she counted at the beginning of her shift, she did not pull the medications out of the cart and just looked at them while still in the drawer to ensure the count was still correct.Review of the witness stated written by LPN #801 revealed she stated on 04/10/26 the card of Resident #32's Oxycodone did not have any taped in medications and that when she counted on 04/13/26 she noticed the medications in the #2 and #6 slots were taped, and the medications in those slots did not match the Oxycodone in the remaining slots.Interview on 04/27/26 at 12:45 P.M. with the Regional Director of Clinical Operations (RDCO) revealed through investigation it was discovered the two medications taped into Resident #32's card of Oxycodone were melatonin. The RDCO stated they were unable to identify who took or where the two missing Oxycodone went but stated they were missing. She stated they notified the pharmacy of the missing Oxycodone and wanted to see if the resident was due back any monies. She stated they did this even though the medications were discontinued. When asked why the facility unsubstantiated the allegation of misappropriation, she had no answer.Review of the undated facility policy titled Medication Controlled (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drugs and Security revealed the purpose of this policy was to provide direction for the nurse regarding processes of operation for the administration and control of narcotics. Additionally, it stated drug diversion would be treated as misappropriation of Resident Property and the Board of Nursing would be notified as appropriate for known drug diversions or suspected drug diversion after careful review and evidence collection.