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	02/12/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, review of manufacture's guidelines and facility policy review, the facility did not ensure medications were not left at the bedside for Resident #42. This affected one (Resident #42) of three residents observed for medication administration. The facility also failed to store medications in a manner to preserve efficacy and proper discard time frames affecting eight (Residents #59, #6, #9, #48, #18, #33, #55, and #57) medications observed during medication storage observation. The facility census was 70.Findings include:1. Review of the medical records for Resident #42 revealed the date of admission as 12/19/25. Significant diagnoses included chronic obstructive pulmonary disease (COPD) and acute respiratory failure. Significant orders included Dulera Inhalation 200/5 micrograms per actuation (mcg/act) (a prescription inhaler to reduce inhalation and open airways), two puffs inhale orally two times a day for asthma and Spiriva (a prescription inhaler used for daily maintenance of respiratory conditions) 2.5 mcg/act two puffs one time daily for COPD. There were no orders for the resident to self-administer medications.Review of the assessments completed in the medical record revealed no assessment for self-medication administration for Resident #42.Review of the Minimal Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating Resident #42 was cognitively intact.Review of the care plan dated 12/31/25 revealed Resident #42 had COPD with shortness of breath while lying flat. An intervention included administering medications as ordered.An observation on 02/09/26 at 6:56 P.M. revealed Resident #42 to be lying in bed. There were two inhalers (Dulera and Spiriva) on the overbed table next to the resident.An interview on 02/09/26 at 7:00 P.M. with Licensed Practical Nurse (LPN) #355 verified presence of the Dulera and Spiriva inhalers on the overbed table next to Resident #42.An interview on 09/10/26 at 1:00 P.M. with Regional Director of Clinical Operations (RDCO) # 344 verified the lack of a self-medication administration assessment for Resident #42.2. On 02/10/26 at 11:00 A.M. an observation of the medication cart identified as the South Center Cart with LPN #350 revealed a bottle of over-the-counter acidophilus (probiotic), 200 count, opened and unlabeled. The acidophilus was used for Residents #6, #9, #48, and #59. The observation further revealed a bottle of over-the-counter famotidine 10 milligrams (mg) (reduces stomach acid), 300 count that was opened and unlabeled. The famotidine was used for Residents #18, #33, #55 and #57. There was an aspart insulin pen for Resident #59 unlabeled as to when it was opened. There was an open vial of lispro insulin, 10 milliliters (ml) for Resident #59 unlabeled as to when it was open. LPN #350 verified the findings at the time of the observation. An interview with RDCO #344 on 02/10/26 at 11:10 A.M. revealed medications were to be dated when opened.A review of the manufacturers package insert for aspart insulin revealed that a single patient use penfill cartridge should not be used after 28 days of being opened.A review of the manufacturers package insert for lispro insulin revealed that the insulin should not be used after 28 days of being opened.3. An observation of the South medication storage room on 02/10/26 at 11:15 A.M. revealed a one ml vial of Tubersol serum (a serum injected to test for (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tuberculosis). The vial was open, unboxed and not labeled as to when it was opened. LPN #349 verified the opened, unboxed and unlabeled vial of Tubersol at the time of the observation.A review of the manufacturers package insert for Tubersol revealed, a vial of Tubersol which has been opened and in in use for 30 days should be discarded.A review of the facility policy titled; Medication Administration that was undated revealed medications should never be left unattended. The policy further revealed for medications that expire, label the date opened on the label (insulin, irrigation solutions etc.).

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure the smoking area of the courtyard was maintained in a clean and sanitary manner free from cigarette butts. This had the potential to affect all six (Residents #16, #21, #34, #41, #56, and #66) identified by the facility as utilizing the smoking area. The facility census was 70.Findings include:Observation on 02/10/26 at 4:25 P.M. of the courtyard smoking area revealed multiple cigarette butts (more than 50) scattered on the ground and in the snow. Interview at the time of the observation with Licensed Practical Nurse (LPN) #355 verified the observation and stated she was not sure who was responsible for cleaning up the cigarette butts. Observation on 02/10/26 at 4:42 P.M. of the courtyard smoking area with the Administrator and Regional Director of Clinical Operations (RDCO) #344 verified the multiple cigarette butts on the ground and snow. The Administrator stated it was the responsibility of maintenance to ensure the smoking area was clean.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on record review, observation, interview and facility policy review, the facility failed to ensure accurate and complete clinical documentation and failed to notify the physician of resident refusals of a prescribed cervical collar (C collar). This affected one (Resident #6) of two residents reviewed for orthotic devices. The facility census was 70.Findings include:Review of the medical record for Resident #6 revealed an admission date of 11/17/25. Diagnoses included right femur fracture, dementia, abnormal posture, vertebral fracture, collarbone fracture, pelvis fracture, insomnia and muscle weakness.Review of the physician's order dated 11/18/25 revealed Resident #6 had an order for a C collar (medical device designed to restrict movement of the neck and upper spine to allow injuries to heal, protect against further damage, or provide relief from severe pain) to be in place at all times, only to be removed for showers and to check skin integrity.Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was moderately cognitively impaired. He required substantial to maximum assistance for oral care and was dependent on staff for eating, showering, toileting, dressing and personal hygiene.Review of the care plan dated 12/01/25 revealed Resident #6 had an activity of daily living (ADL) self-care deficit due to multiple fractures. Interventions included ensuring the C collar was in place at all times, only to be removed for skin integrity and showers and ensuring the call light was in reach. Resident #6 was admitted with multiple fractures including cervical, thoracic, vertebral and clavicle fractures. Interventions included orthopedic follow up per orders and encouraging the resident to actively participate in the rehabilitation process.Review of Resident #6's physicians' orders for February 2026 revealed the order for a C collar remained an active order.Review of the Treatment Administration Record (TAR) for February 2026 revealed Resident #6's C collar was checked for placement on day, evening and night shift on 02/01/26, 02/07/26, 02/08/26, 02/09/26 and 02/10/26, on day shift on 02/02/26 on day and evening shift and on night shift on 02/06/26. Resident #6 was in the hospital from [DATE] at 3:18 P.M. until 02/06/26 at 11:51 P.M.Observation and interview on 02/10/26 at 1:01 P.M. with Resident #6 revealed he was lying in bed watching TV. The C collar was noted to be on the nightstand next to the bed. Resident #6 revealed he was no longer required to wear the C Collar.Interview on 02/10/26 at 1:08 P.M. with Licensed Practical Nurse (LPN) #349 revealed Resident #6 no longer wore a C collar and revealed it had been discontinued a few weeks prior.Interview on 02/11/26 at 10:30 A.M. with the Director of Nursing (DON) revealed Resident #6 had been refusing to wear the C Collar since he was told he would only need to wear it for 12 weeks when he was in the hospital. She confirmed that staff had been documenting it was in place, but reported she was told he was removing it after it was checked for placement. She confirmed there was no documented evidence of the refusals or removals. She further revealed Resident #6 had not been seen by the orthopedic team for the C collar since admission, and calls to the doctor's office for advisement regarding the C collar had not been returned. She could provide no evidence of attempts to contact the orthopedic doctor's office.Review of the undated facility policy titled Routine Resident Care revealed the facility would attend to the total medical, nursing, physical, emotional, social and spiritual needs of residents, including licensed staff providing implementation and evaluation of needs, coordinating and overseeing resident care with accountability for nursing interventions, provide routine care including maintaining proper body positioning and alignment and assisting with special devices such as prosthesis and other devices.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review, observation, interview and facility policy review review, the facility failed to ensure falls were thoroughly investigated for Resident #18 and failed to ensure safe smoking practices were followed for Resident #16. This affected one (Resident #18) of three residents reviewed for falls and one (Resident #16) of three residents reviewed for smoking. The facility identified six residents (Residents #16, #22, #34, #41, #56 and #66) in the facility who smoked. The facility census was 70.Findings include: 1. Review of the medical record for Resident #18 revealed an admission date of 06/03/24. Diagnoses included congestive heart failure (CHF), diabetes, morbid obesity, hypertension, depression and anxiety. Review of the fall risk assessment dated [DATE] revealed Resident #18 was at risk for falls. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #18 was cognitively intact. She required substantial/maximum assistance with oral hygiene, upper body dressing, personal hygiene, rolling left to right and right to left, sitting to lying and lying to sitting and was dependent on staff for showers, transfers, lower body dressing and applying and removing footwear. She was frequently incontinent of urine and always incontinent of bowel. Review of the care plan dated 04/16/25 revealed Resident #18 was at risk for falls due to impaired mobility. Interventions included ensuring the room was free of hazards, initiating neurological checks if a fall was unwitnessed, ensuring adequate lighting at night and ensuring the call light was within reach. Review of the nursing progress note dated 05/09/25 at 6:50 P.M. revealed Resident #18 was heard yelling from her room and was found on the floor with her head on her handbag. She complained of severe pain in her right knee, and movement of her right leg was very limited. No changes in mental status or observed, her vital signs included blood pressure 140/60, heart rate 56, temperature 97.1 degrees Fahrenheit (F), respirations 18 and oxygen saturation 97 on room air. She could not explain what happened prior to the fall. The resident's family was notified as well as the unit manager and emergency medical services (EMS) were contacted, and the resident was taken to the emergency department (ED) around 8:20 PM. Neurological checks were initiated and continued until the resident left for the ED. Review of the nursing progress note dated 05/10/25 at 6:18 A.M. revealed Resident #18 was admitted to the hospital with a right distal femur fracture. Review of the undated facility investigation revealed Resident #18 was heard yelling from her room and was found on the floor. She complained of severe pain in her knee; her vital signs were obtained, and she could not recount the events that led to the fall. She was subsequently sent to the ED. Immediate interventions taken were a range of motion assessment, head to toe body check, locked bed wheels and a urine drug screen was ordered. The resident was found on her right side, was last toileted around 6:30 P.M., the environment was quiet, she was barefoot, the alarm was sounding, a mattress was on the floor, and the bed was in the low position. A witness statement obtained from Registered Nurse (RN) #350) who was assigned to Resident #18 at the time revealed after dinner the resident was falling asleep in her wheelchair. He asked her if she wanted to lie down, and she refused. Shortly after that she was heard yelling and observed lying on the floor complaining of pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no other witness statements or descriptions of the event. Interview on 02/11/26 at 10:24 A.M. with the Director of Nursing (DON) revealed Resident #18 was in her wheelchair when she fell but confirmed an immediate intervention was to ensure the bed wheels were locked was added. She could not explain why there were no other witness statements and nothing to address where the resident was located immediately prior to the fall or why this intervention was implemented if the fall occurred from the wheelchair. Interview on 02/11/26 at 11:20 A.M. with Social Service Designee (SSD) #363 revealed she was the certified nurse aide (CNA) assigned to care for Resident #18 at the time of the fall. She revealed Resident #18 was in her wheelchair and was offered to lie down, but she chose not to. She heard screaming from the residents' room and immediately went to find her on the floor. She then notified the nurse. She revealed her call light was not on at the time. She also confirmed she was never asked to provide a witness statement regarding the incident. Interview on 02/11/26 at 10:58 A.M. with Resident #18 revealed she fell from her wheelchair. She could not recall specific details of the event but does recall breaking her leg. Interview on 02/11/26 at 11:36 A.M. with the DON confirmed the fall investigation for Resident #18 was inconclusive and did not provide enough detail, including witness statements, to consider the investigation thorough. Review of the undated facility policy titled Fall Prevention and Management revealed the therapy department would screen residents to assist in identification of potential activities of daily living issues that could be addressed to prevent or minimize their risk of falls as well as make recommendations for equipment, the DON and Executive Director would be notified if a resident was transferred out of the facility due to a fall, the facility would ask the resident what happened when they fell, even if the resident had dementia, identify any witnesses and ask them to write a statement immediately. The facility would attempt to identify why the resident fell, and immediate interventions would be put in place to prevent further falls. 2. Review of the medical record of Resident #16 revealed an admission date of 11/07/25. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, lung cancer, major depressive disorder, dependence on supplemental oxygen, alcohol abuse, anxiety disorder, and nicotine dependence. Review of the smoking acknowledgement form dated 11/07/25 revealed Resident #16 received a copy of the smoking policy for the facility. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #16 had intact cognition, required supervision or touch assistance with transfers, and used a wheelchair. The assessment also indicated the resident used tobacco. Review of the plan of care revised 02/03/26 revealed Resident #16 utilized nicotine products (cigarettes) and was an independent smoker. Interventions included educating the resident/resident representative (if applicable) to facility smoking policy, obtain resident signature. Review of the smoking assessment dated [DATE] indicated Resident #16 was an independent smoker. Interview on 02/10/26 at 10:38 A.M. with Resident #16 revealed he was independent smoker and kept his own smoking materials. Resident #16 stated the nurses kept the smoking materials for the supervised (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smokers. No smoking materials were observed at this time in Resident #16's room. Observation on 02/10/26 at 4:13 P.M. of Resident #16 outside in the courtyard smoking with two other residents. At 4:33 P.M. Resident #16 was observed leaving the courtyard smoking area and self-propelling to his room. Interview at this time with Resident #16 revealed he keeps his smoking material on him and showed a pack of cigarettes and lighter sitting on the left side of his wheelchair covered by his jacket. Interview on 02/10/26 at 4:42 P.M. with the Administrator and Regional Director of Clinical Operations (RDCO) #344 revealed the residents and/or family were responsible for purchasing smoking material and when they bring them in they were to turn them into the nurses station. Both the Administrator and RDCO #344 were made aware of Resident #16 observed with his smoking material in his room. The Administrator stated the resident was not supposed to have them on him and that they would need to re-educate the resident. Follow-up interview on 02/11/26 at 9:30 A.M. with the Administrator stated she had talked to Resident #16 on 02/10/26 and after about 45 minutes he handed her his smoking materials. Review of the undated facility policy titled Resident Smoking Guidelines revealed facility staff will store smoking materials in a secure area when not in use by the resident for both independent and supervised smokers. All smoking materials will be maintained by the facility staff and provided to the resident on request. Smoking materials will be returned to the facility staff upon completion of smoking.

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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** Based on record review, interview, observation and facility policy review, the facility failed to ensure oxygen tubing was changed every seven days. This affected one (Resident #42) of two residents reviewed for respiratory care and had the potential to affect eight additional (Residents #1, #5, #7, #16, #35, #48, #54, and #65) identified by the facility as utilizing oxygen. The facility census was 70.Findings include: A review of medical records for Resident #42 revealed the date of admission as 12/19/25. Significant diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and unspecified acute respiratory failure. A review of significant orders revealed no current physician order for oxygen therapy, including flow rate, method of delivery, indication for use, or parameters for monitoring. No orders for oxygen tubing management.Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating Resident #42 was cognitively intact.Review of the care plan dated 12/31/25 revealed Resident #42 had altered cardiovascular status related to combined systolic and diastolic CHF and chronic atrial fibrillation. An intervention included administer oxygen as ordered. Review of a progress note dated 12/31/25 revealed Resident #42 was on two liters per minute of oxygen. Further review of progress notes revealed on 01/30/26, Resident #42 was receiving oxygen via nasal cannula.An observation on 02/09/26 at 7:00 P.M. of Resident #42 revealed he was in bed with oxygen on via nasal cannula (a tube in the nose that delivers oxygen). The tubing was dated 01/24/26. Licensed Practical Nurse (LPN) #355 verified the date of 01/24/26 on the oxygen tubing of Resident #42 at the time of the observation. LPN #355 stated oxygen tubing was to be changed every seven days and as needed if it became soiled.A review of the undated facility policy titled Supplemental Oxygen using Nasal Cannula revealed under section III, subpoint b that nasal cannulas and tubing are changed weekly or when soiled and labeled with date opened.