

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Salem Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3445 Boone Road SE Salem, OR 97317	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>22762</p> <p>Based on interview and record review, it was determined the facility failed to ensure allegation of verbal abuse was reported to the SSA (State Survey Agency) within the required reporting time of two hours for 1 of 3 sampled residents (#4) reviewed for verbal abuse. This placed residents at risk for potential ongoing abuse. Findings include:</p> <p>Resident 4 was admitted to the facility in 1/2024, with diagnoses including bilateral leg fractures and chronic pain.</p> <p>Resident 4's 1/17/24 Admission MDS revealed she/he was cognitively intact and had no behaviors. A Grievance Community Form dated 1/18/24, indicated Resident 4 reported to Staff 4 (LPN/RCM) an incident involving Witness 1 (Agency Nurse). Resident 4 reported Witness 1 was rude and disrespectful during a dressing change and failed to use caution when moving her/his fractured leg. Staff 4 indicated she assisted Resident 4 with completing the Grievance Community Form and contacted Witness 1 and did not receive a call back.</p> <p>A Grievance Community Form dated 1/22/24, revealed Resident 4 and her/his family requested to talk with Staff 4 a second time regarding the 1/18/24 incident. Resident 4 reported to Staff 4 she/he experienced pain when Witness 4 moved her/his foot and it was unprofessional and she/he was frightened. Staff 4 documented the incident was addressed on 1/18/24, and Resident 4 and her/his family were happy with resolution.</p> <p>On 2/13/24 the SSA received a FRI for the facility's 1/18/24 incident reported by Resident 4. This was 18 days after the allegation of verbal abuse should have been reported to the SSA. The FRI revealed the facility had leadership changes on 2/13/24, and upon review of the grievance log, the incident was deemed appropriate to be reported to the SSA and an investigation was ongoing at this time.</p> <p>During an interview on 5/17/24 at 9:58 AM, Staff 2 (DNS), Staff 3 (Assistant DNS) and Staff 4 (LPN/RCM) acknowledged the verbal abuse incident for Resident 4 was not reported timely to the SSA.</p>

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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>22762</p> <p>Based on interview and record review, it was determined the facility failed to thoroughly investigate an allegation of verbal abuse for 1 of 3 sampled residents (#4) reviewed for verbal abuse. This placed residents at risk for potential ongoing abuse. Findings include:</p> <p>Resident 4 was admitted to the facility in 1/2024, with diagnoses including bilateral leg fractures and chronic pain.</p> <p>Resident 4's 1/17/24 Admission MDS revealed she/he was cognitively intact and had no behaviors.</p> <p>Resident 4's medical record indicated facility Grievance Community Forms were completed on 1/18/24 and 1/22/24 related to an allegation of verbal abuse by Witness 1 (Agency Nurse). Resident 4 reported Witness 1 was rude and disrespectful and failed to use caution when moving her/his leg during a dressing change.</p> <p>On 2/13/24 the SSA (State Survey Agency) received a FRI for the facility's 1/18/24 incident reported by Resident 4, which was 18 days after the allegation of verbal abuse occurred. The FRI indicated an investigation was ongoing at this time.</p> <p>The facility's 1/22/24 Incident Report included three entries dated 2/15/24 titled RCM [Resident Care Manager] Investigation, which revealed information regarding Resident 4's allegation of verbal abuse on 1/18/24. The RCM investigation included information from the Grievance Community Forms and included the incident occurred on 1/17/24 and involved Witness 1. The investigation lacked observations of Resident 4 following the verbal abuse allegation, interviews with potential witnesses or staff, and record review for relevant information pertinent to the incident.</p> <p>During an interview on 5/17/24 at 9:58 AM, Staff 2 (DNS), Staff 3 (Assistant DNS) and Staff 4 (LPN/RCM) indicated the initial process following an allegation of abuse included completing a quick investigation, submitting a FRI if appropriate, and removing the problem or staff member. Staff 2 stated a full investigation is started following completion of the initial actions. Staff 2 stated the incident involving Resident 4 was first investigated as a grievance and later identified to be an allegation of abuse by Witness 2 (Nurse Consultant). Staff 2 acknowledged Resident 4's allegation of verbal abuse lacked a thorough investigation.</p>		