STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385234	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Transitional Care	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)
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. 48830 Based on interview and record review it was determined the facility failed to ensure residents were treated with dignity for 1 of 2 sampled residents (#1) reviewed for dignity and abuse. This placed residents at risk for lessened quality of life. Findings include: The facility's Dignity Policy, last revised 2/2021, indicated staff were to treat all residents with dignity and speak respectfully. Resident 1 was admitted to the facility in 6/2024 with diagnoses including dementia and a stroke with speech deficit. A 6/25/24 Admission MDS indicated Resident 1 was unable to participate in cognitive testing due to a speech deficit but did understand yes and no questions. An 8/10/24 revised care plan revealed Resident 1 had known behaviors of fidgeting, anger, frustration, and yelling. The care plan included triggers and interventions. A review of a 8/12/24 facility investigation regarding alleged lack of dignity and respect indicated Staff 3 (LPN) willfully intimidated Resident 1. Staff 3 was terminated from employment. On 10/14/24 at 12:39 PM Staff 4 (CNA) stated Resident 1 had behaviors of yelling and she observed Staff 3 taunt the resident by encouraging her/him to yell louder. Staff 4 stated she observed Staff 3 incorrectly transfer the resident by picking the resident up like a baby and placing on the bed. Staff 4 stated she reported Staff 3 to facility management. On 10/14/24 at 3:02 PM Staff 5 (CNA) stated Resident 1 had behaviors including yelling. The resident sat at the nurse's station frequently and one evening Staff 5 observed Staff 3 become annoyed with Resident 1's yelling. Staff 3 stood over the resident and placed his hand above the resident's head, like dangling a treat if she/he behaved. Staff 5 stated she observed Staff 3 incorrectly transfer the resident and scooped the resident up like a child and placed the resident on the bed. Staff 5 stated she reported Staff 3 to facility management. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 12:53 PM Staff 3 stated he worked with Resident 1 and became annoyed when the resident yelled throughout his shift. Staff 3 stated he frequently reminded her/him to be quiet in a not so nice tone. Staff 3 stated he did stand over the resident while she/he yelled. Staff 3 stated he did scoop the resident up for transfers. On 10/15/24 at 1:48 PM Staff 2 (DNS) acknowledged the findings and stated Staff 3 was terminated from employment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to ensure Staff 3 (LPN) adhered to professional standards of practice regarding residents' dignity and plan of care for 1 of 2 sampled residents (#1) reviewed for abuse and dignity. This placed residents at risk for abuse and undignified treatment. Findings include: The Oregon State Board of Nursing Conduct Derogatory to the Standards of Nursing ([NAME] [PHONE NUMBER]) outlined nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following: -Failing to respect the dignity and rights of residents; - Failing to develop, implement and/or follow through with the plan of care; Resident 1 was admitted to the facility in 6/2024 with diagnoses including dementia and a stroke with speech deficit. An 8/10/24 revised care plan revealed Resident 1 had known behaviors of fidgeting, anger, frustration, and yelling. The care plan included triggers and interventions. A review of an 8/12/24 facility investigation regarding alleged lack of dignity and respect indicated Staff 3 (LPN) willfully intimidated Resident 1. On 10/15/24 at 12:53 PM Staff 3 stated he worked with Resident 1 and became annoyed when the resident yelled throughout his shift. Staff 3 stated he frequently reminded her/him to be quiet in a not so nice tone. Staff 3 stated he did stand over the resident while she/he yelled. Staff 3 stated he did scoop the resident up for transfers. On 10/15/24 at 1:48 PM Staff 2 (DNS) acknowledged the findings and stated Staff 3 was terminated from employment. Refer to F550.