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	01/29/2026

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide transfer assistance for 1 of 3 sampled residents (# 4) reviewed for ADL assistance. This placed residents at risk for unmet care needs.Resident 4 was admitted to the facility in 10/2025 with diagnoses of sepsis (unspecified organism), lobar pneumonia, and acute respiratory failure with hypoxia. A Nursing Care Note dated 10/31/25 documented Resident 4 was assisted back to her/his room after dinner. The assisting staff left the resident alone in her/his wheelchair in the room while obtaining assistance for a two-person transfer. Staff did not return to the resident's room for over one hour. Resident 4's MDS admission assessment dated [DATE] indicated the resident had a BIMS score of 14, was cognitively intact and was dependent for wheelchair mobility. A Risk Management Report dated 10/31/25, completed by Staff 12 (LPN), confirmed Resident 4 was left alone in her/his wheelchair in the room for over an hour while awaiting transfer assistance. On 1/26/26 at 2:10 PM, Witness 4 (Complainant) stated her/his family member was left alone in her/his wheelchair for an extended period of time waiting to be transferred into bed. On 1/28/26 at 11:50 AM, Staff 13 (CNA) stated Resident 4 was assigned to the resident on 10/31/25, evening shift. Staff 13 reported she was also assigned dining room duties and was unable to leave the dining room while residents were still eating. Staff 13 stated she requested another CNA to assist Resident 4 back to her/his room. Staff 13 later found Resident 4 sitting alone in her/his wheelchair in the room awaiting transfer to bed. On 1/28/26 at 6:35 PM, Staff 12 (LPN) confirmed completion of a Risk Management Report related to Resident 4 being left alone in her/his wheelchair for over an hour while awaiting transfer assistance. On 1/29/26 at 10:02 AM, Resident 4 stated she/he was left alone in her/his room for approximately one hour and ten minutes waiting to be transferred into bed. Resident 4 stated she/he did not have a call light or phone within reach, experienced pain, and was unable to transfer or ambulate the wheelchair independently. On 1/28/26 at 2:02 PM. Staff 1 (Assistant Administrator in Training), Staff 2 (Field Lead for Oregon/Cascadia), Staff 3 (Chief Nursing Officer), and Staff 4 (Assistant Chief Nursing Officer) all acknowledged Resident 4 should have received more timely transfer assistance.

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
	385234	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Transitional Care	3445 Boone Road SE Salem, OR 97317

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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 - 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 interview and record review it was determined the facility failed to ensure physician orders were followed for 1 of 7 sampled residents (# 2) reviewed for physician orders. This placed residents at risk for medical complications and unmet medication needs. Findings include: Resident 2 was admitted to the facility in 7/2025 with a diagnosis of fracture right lower leg. Resident 2's admission MDS dated [DATE] revealed the resident had a BIMS score of 13 and was cognitively intact. The facility's Risk Management report dated 8/3/25 and a Progress Note dated 8/3/25 identified the facility failed to follow a physician's STAT order placed on 8/1/25 for Lokelma (a medication used to treat high blood potassium levels) for Resident 2. The on-call provider was notified of the missed medication and instructed nursing staff to send the resident to the emergency room. Resident 2 was sent to the emergency room on 8/3/25. On 1/26/25 at 2:59 PM, Witness 2 (Hospital Social Worker) stated the facility failed to administer a physician-ordered medication for Resident 2's elevated potassium level, and the resident was sent to the hospital related to the missed medication. On 1/29/26 at 2:08 PM, Staff 10 (LPN) stated a medication error occurred in August involving Resident 2's Lokelma dose. Staff 10 stated an incident report should have been written but could not recall if one was completed. Staff 10 recalled Resident 2 was sent to the hospital due to the missed medication. On 1/29/26 at 1:11 PM, Staff 6 (RN/RCM) stated she remembered a medication error involving Resident 2's Lokelma but could not recall any details of the findings. On 1/28/26 at 2:02 PM, Staff 1 (Assistant Administrator in Training), Staff 2 (Field Lead for Oregon/Cascadia), Staff 3 (Chief Nursing Officer), and Staff 4 (Assistant Chief Nursing Officer) all acknowledged Resident 2 should have received the STAT Lokelma dose as ordered.