

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/24/2026
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.			
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review it was determined the facility failed to provide a homelike dining environment for 1 of 1 dining rooms reviewed for resident council. This placed residents at risk for an institutional dining experience and lower quality of life. Findings include: A review of the 6/2026 Resident Council Meeting Minutes revealed the residents liked having tablecloths on the tables in the dining room. The dietary department responded stating, labor cuts have eliminated linens on tables. I don't see them coming back any time soon. Random observations from 7/20/26 through 7/24/26 during mealtimes revealed the dining room to not have tablecloths on any table. On 7/22/26 at 2:00 PM during the resident council meeting, the residents in attendance stated the dining room was more inviting with tablecloths and made residents want to eat meals in the dining room. One resident stated she/he ate in her/his room because, the facility doesn't put in the effort, so it makes you not want to put in the effort in coming down to the dining room. The residents stated they were told by the facility due to budget reasons they could not have tablecloths. On 7/22/26 at 4:00 PM Staff 17 (Activity Director) stated the tablecloths in the dining room went away around the time of transition to the new company in December 2025 or January 2026. On 7/24/26 at 12:22 PM Staff 1 (Executive Director) and Staff 3 (CEO Lead) stated they were unsure why the previous administrator discontinued tablecloths in the dining room. Staff 3 stated it was not a direction from upper management and labor cuts would not have anything to do with tablecloths in the dining room. Staff 1 and Staff 3 acknowledged the dining room was not a homelike environment.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to implement appropriate contact precautions for 3 of 3 sampled residents (#s 8, 23 and 125) reviewed for contact precautions. This placed residents at risk for the spread of infection. Findings include: The facility's Contact Precautions policy, dated 9/10/25, indicated to don appropriate PPE before or upon entry into the environment (e.g., room) of resident on contact precautions. 1. Resident 8 was admitted to the facility in 8/2026 with diagnoses including vascular dementia and a stroke. A 7/15/26 care plan revealed Resident 8 had CRE (Carbapenem-resistant Enterobacterales, a bacteria that causes infection in the stomach and is resistant to most antibiotics) and was on Contact Precautions in attempt to prevent transmission of the bacteria. On 7/20/26 at 2:12 PM a Contact Precautions sign was observed outside Resident 8's room. The Contact Precautions sign directed staff to perform hand hygiene, wear gloves and gown upon entering the room, discard the PPE upon exiting and perform hand hygiene again. On 7/20/26 at 2:14 PM Staff 19 (CNA) was observed assisting Resident 8 to eat a snack inside the resident's room. Staff 19 was observed not wearing gloves or a gown. On 7/20/26 at 2:21 PM Staff 19 stated she was unsure when to wear PPE and thought PPE was only needed when Resident 8 required ADL care. Staff 19 reviewed the Contact Precautions sign on Resident 8's door and stated she did not need to wear PPE all the time when in Resident 8's room. On 7/23/26 at 12:34 PM Staff 5 (RNCM) stated staff were to wear a gown and gloves every time they were in a room for a resident on Contact Precautions. On 7/24/26 at 11:14 AM Staff 16 (IP) stated staff were to wear a gown and gloves every time they entered a room of a resident on Contact Precautions, especially when assisting the resident to eat, and staff were to wash their hands with soap and water before exiting the resident's room. 2. Resident 23 was admitted to the facility in 7/2026 with diagnoses including C. diff (Clostridium difficile, a bacterium which causes an infection of the colon) and diabetes. A 7/6/26 care plan revealed staff were to follow Contact Precautions when they provided care to Resident 125 due to a diagnosis of C. diff. On 7/23/26 at 10:40 AM a Contact Precautions sign was observed outside Resident 23's room. The Contact Precautions sign directed staff to: perform hand hygiene, wear gloves and gown upon entering room, and wash hands with soap and water prior to exiting the resident room. On 7/23/26 at 10:42 AM Staff 20 (CNA) was observed in Resident 23's room and was not wearing gloves or a gown while placing Resident 23's personal belongings in a bag and picking up Resident (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	23's water container from the bedside table. Staff 20 was observed to exit Resident 23's room without washing her hands with soap and water. Staff 20 was observed to speak with the nurse and then wash her hands with soap and water at the sink located at the nurses station. On 7/23/26 at 10:49 AM Staff 20 confirmed she was not wearing the required PPE while in Resident 23's room and did not wash her hands as required prior to exiting the resident's room. On 7/23/26 at 12:34 PM Staff 5 (RNCM) stated staff were to wear a gown and gloves every time they were in a room for a resident on Contact Precautions. On 7/24/26 at 11:14 AM Staff 16 (IP) stated staff were to wear a gown and gloves every time they entered a room for a resident on Contact Precautions, especially when touching items in the residents room, and staff were to wash their hands with soap and water before exiting the resident's room. 3. Resident 125 admitted to the facility in 7/2026 with diagnoses including C. diff (Clostridium difficile, a bacterium which causes an infection of the colon). A 7/17/26 Care Plan revealed staff were to follow Contact Precautions when they provided care to Resident 125 due to a diagnosis of C. diff. On 7/20/26 at 10:32 AM a Contact Precautions sign was observed outside Resident 125's room. The Contact Precautions sign directed staff to: perform hand hygiene with soap and water, wear gloves and gown upon entering room, and wash hands with soap and water prior to exiting the resident room. On 7/20/26 at 10:35 AM Staff 9 (CNA) was observed to exit Resident 125's room without washing her hands with soap and water. Staff 9 stated she planned to wash her hands outside of the resident's room. Staff 9 reviewed the Contact Precautions sign on Resident 125's door and confirmed it directed her to wash her hands with soap and water before she exited the room. On 7/20/26 at 12:51 PM Staff 10 (CMA) was observed to exit Resident 125's room without washing his hands with soap and water. Staff 10 confirmed he did not wash his hands with soap and water before he exited the resident's room. On 7/20/26 at 12:54 PM Staff 12 (CNA) entered Resident 125's room without donning a gown or gloves to deliver Resident 125's room to deliver a lunch tray and did not wash her hands with soap and water before she exited the room. Staff 12 stated she believed it was not necessary to follow the Contact Precautions when she dropped off a meal in Resident 125's room. On 7/23/2026 at 2:18 PM Staff 2 (DNS) stated staff were to wear a gown and gloves every time they entered a room for a resident on Contact Precautions and were to wash their hands with soap and water before they exited Resident 125's room.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage) notification to 1 of 3 sampled residents (#130) reviewed for Beneficiary Notification. This placed residents at risk for lack of information related to financial liability. Findings include: Resident 130 admitted to the facility on [DATE] with Medicare Part A benefits. A Notice of Medicare Non-Coverage was issued to Resident 130 on 2/14/26 with the last day covered by Medicare Part A of 2/17/26. A review of the medical record revealed Resident 130 remained private pay in the facility from 2/18/26 to 2/24/26, and there was no evidence of a SNF ABN. On 7/22/26 at 2:00 PM Staff 13 (Resident Support Services Assistant) confirmed she issued a Notice of Medicare Non-Coverage with a last Medicare covered day of 2/17/26 to Resident 130. Staff 13 confirmed Resident 130 remained in the facility after 2/17/26 and she/he did not receive a SNF ABN. On 7/24/26 at 12:53 PM Staff 1 (Executive Director) acknowledged the SNF ABN was not issued to Resident 130.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to complete a comprehensive assessment within the regulatory timeframe for 1 of 2 sampled residents (#128) reviewed for resident assessment. This placed residents at risk for unassessed care needs. Findings include: Resident 128 admitted to the facility on [DATE]. A 7/9/2026 admission MDS was completed on 7/22/26, five days after the regulatory timeframe. On 7/22/26 at 12:06 PM Staff 7 (RN MDS Coordinator) confirmed Resident 128's admission MDS was not completed within the regulatory timeframe.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review it was determined the facility failed to complete a Significant Change MDS within the required timeframe for 1 of 1 sampled resident (#2) reviewed for hospice. This placed residents at risk for unassessed needs. Findings include: Resident 2 was admitted to the facility in 1/2026 with diagnoses including diabetes and chronic obstructive pulmonary disorder. An Election of Benefits and Informed Consent document revealed Resident 2 was admitted to hospice services on 5/24/26. The Significant Change MDS was completed on 6/18/26, 11 days after the required 14-day timeframe. On 7/22/26 at 12:27 PM Staff 8 (MDS Coordinator) acknowledged the Significant Change MDS completion date exceeded the required 14-day timeframe.		

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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 interview and record review it was determined the facility failed to initiate treatment for an identified skin issue for 1 of 1 sampled resident (#32) reviewed for pressure wounds. This placed residents at risk for worsening wounds. Findings include: Resident 32 admitted to the facility on [DATE] with diagnoses including sepsis. A 7/19/26 Skin Inspection Evaluation revealed Resident 32 admitted to the facility with an open lesion and redness to her/his coccyx. A review of Resident 32's medical record revealed no orders or care instructions related to Resident 32's coccyx skin lesion. On 7/20/26 at 2:22 PM Resident 32 stated she/he admitted from the hospital with a crack in my seat and the facility was supposed to continue treating the area, but she/he had not yet heard an update on it. On 7/22/26 at 1:15 PM Staff 11 (LPN) stated she completed the Skin Inspection Evaluation on 7/19/26 when Resident 32 admitted to the facility and recalled there was a small skin area identified. Staff 11 did not recall if Resident 32's skin area was an actual wound and stated she passed it along to the next shift to follow up on care. On 7/23/26 at 11:13 AM Staff 14 (LPN) stated she worked with Resident 32 and was not aware of any current wounds. On 7/23/26 at 12:13 PM Staff 5 (RNCM) reviewed Resident 32's Skin Inspection Evaluation and stated the nurse was expected to request care orders for any identified skin concerns. On 7/23/26 at 1:29 PM Staff 5 stated Resident 32's skin was observed and confirmed there were no orders in place for care. Staff 5 stated she expected the nurse who identified the skin issue to notify the provider and request treatment.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary antihypertensive and anticonvulsant medications for 1 of 6 sampled residents (#112) reviewed for unnecessary medications. This placed residents at risk for adverse side effects of medication. Findings include: Resident 112 was admitted to the facility in 4/2026 with diagnoses including depression and diabetes. A review of Resident 112's Allergy List included an allergy to gabapentin (an anticonvulsant medication). The 4/17/26 admission MDS revealed Resident 112 had a BIMS score of 14, indicating she/he was cognitively intact. On 4/26/26 a public complaint was received by the State Agency alleging the facility administered Resident 112 gabapentin and hydralazine (an antihypertensive medication) that were not prescribed to her/him. Resident 112 was allergic to gabapentin and was sent to the hospital emergency room. A 4/26/26 at 3:06 PM Progress Note by Staff 21 (LPN) revealed a CMA administered the wrong medication including gabapentin 300 mg and hydralazine 50 mg to Resident 112. It was noted Resident 112 had an allergy to gabapentin. Staff 21 notified the resident of the medication error, assessed her/him, notified the resident's emergency contact and the physician, who directed the staff to send the resident to the emergency room. A 4/26/26 at 10:38 PM Progress Note revealed Resident 112 returned to the facility from the hospital emergency room with no new orders. A Medication Error Report dated 4/27/26 revealed Staff 22 (CMA) mistakenly entered the wrong resident room and administered gabapentin 300 mg and hydralazine 50 mg to Resident 112 on 4/26/26. Staff 22 immediately realized the mistake and notified Staff 21 of the medication error. On 7/23/26 at 4:04 PM Staff 22 stated on 4/26/26 she was covering a hall she never worked on before and mixed up the resident rooms. Staff 22 stated she realized her mistake right away and notified Staff 21. Staff 22 stated it was an accident and she learned her lesson to always complete the five rights of medication administration- the right patient, the right medication, the right dose, the right route and the right time. On 7/24/26 at 11:49 AM Staff 2 (DNS) stated she expected staff who administered medication to residents to verify the five rights, look at the resident picture in the medical record and to ask the charge nurse if they were unsure. Staff 2 acknowledged Resident 112 was administered gabapentin and hydralazine unnecessarily.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review it was determined the facility failed to ensure there was a designated staff member responsible for collaborating and communicating with hospice representatives, and that the care plan included the hospice plan of care for 1 of 1 sampled resident(#2) reviewed for hospice. This placed residents at risk for uncoordinated and unmet hospice care needs. Findings include:Resident 2 was admitted to the facility in 1/2026 with diagnoses including diabetes and chronic obstructive pulmonary disorder.An Election of Benefits and Informed Consent document revealed Resident 2 was admitted to hospice services on 5/24/26. Resident 2's Care Plan did not include hospice related information, such as a Hospice Plan of Care. On 7/22/26 at 12:06 PM Staff 6 (RNCM) indicated she did not know what information needed to be on a care plan for residents receiving hospice services and did not know which staff members were responsible for collaborating and coordinating with hospice representatives for Resident 2. Staff 6 acknowledged Hospice Plan of Care information was not included in Resident 2's Care Plan. On 7/22/26 at 12:34 PM Staff 2 (DNS) acknowledged the facility did not have designated staff members identified to communicate and collaborate with hospice representatives for Resident 2, and Hospice Plan of Care information was not included in Resident 2's Care Plan.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review it was determined the facility failed to ensure the state survey inspection results contained the most recent survey results for 1 of 1 facility reviewed for resident council. This placed residents and the public at risk for not being informed of the facility's survey history. Findings include: On 7/22/26 at 2 PM during the resident council meeting, the residents in attendance stated they were not aware of where to find the state survey inspection results in the facility. On 7/22/26 at 4:14 PM an observation was made of the Survey Findings Binder at the front entrance to the facility across from the receptionist desk. The binder did not contain all of the 2025 survey findings and there were no 2026 survey findings included. On 7/22/26 at 4:48 PM Staff 1 (Executive Director) stated the administrator oversaw updating the state survey inspection result binder. Staff 1 acknowledged the binder was not updated with the most recent survey results.		