STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495087	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Health & Rehabilitation	1945 Roanoke Blvd Salem, VA 24153

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility document review, the facility staff failed to provide written notification of reasons for transfer or discharge to the resident and the resident's representative(s) and failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman for two (2) of seven (7) sampled residents and/or residents' representatives, (Resident #3 and Resident #4). The findings include: 1. For Resident #3, the facility staff failed to provide the resident or the resident's representative written notice of the reason(s) of transfer/discharge to the hospital on [DATE] and failed to notify the Office of the State Long-Term Care Ombudsman of the transfer/discharge on [DATE], 11/23/24 and 12/5/24. Resident #3's diagnosis list indicated diagnoses that included, but were not limited to, Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Hypertension, Post Traumatic Stress Disorder, Iron Deficiency Anemia, Chronic Kidney Disease-Stage 3 (three), Depression, Presence of Coronary Angioplasty Implant and Graft, Cognitive Communication Deficit, Diabetes Mellitus Type 2 (two), Bipolar Disorder, Anxiety Disorder, and Gastrointestinal Hemorrhage. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 10/31/24, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record indicated Resident #3 was transferred to the hospital on [DATE], 11/23/24, and 12/5/24. Written notifications of reason for transfer or discharge were provided to Resident #3 and the residents representative for the discharges/transfers on 11/5/24 and 12/5/24, but a written notification for reason of transfer/discharge could not be located for the transfer/discharge that occurred on 11/23/24. Surveyor requested evidence of a written notification for reason of transfer/discharge for 11/23/24 to the resident and resident representative and evidence the ombudsman was provided with written notification for reason for discharges on 11/5/24, 11/23/24, and 12/5/24. This concern was discussed at the pre-exit meeting on 2/26/25 at 1:44 PM with the administrator, director of nursing, regional director of clinical services, and assistant director of nursing. (continued on next page)

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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 2:09 PM, regional director of clinical services informed surveyor that social worker could not locate evidence the local long-term care ombudsman received notification for any of Resident #3's discharges/transfers to the hospital and no evidence could be located of the resident and resident representative receiving written notice for the reason of transfer/discharge on [DATE]. Surveyor requested and received a facility policy, titled, Notice of Transfer/Discharge with an effective date of 1/6/20, that read in part, .4. Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative .notification shall be made as soon as reasonably possible . 7. Provide designated copies of the completed .Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman .8. Scan a copy of the Notice of Transfer/Discharge into the patient's medical record .9. Once the document has been scanned .complete a Social Work and Discharge Planning Progress Note confirming the following: a. Date Patient and/or RP (resident representative) were given notice and the method in which they received notice. b. Date the notice was sent to the Ombudsman and method by which it was sent . No further information regarding this concern was presented to the survey team prior to the exit on 2/26/25. 2. For Resident #4, the facility staff failed to provide written notice to the Office of the State Long-Term Care Ombudsman of the reason for transfer/discharge on [DATE]. Resident #4's diagnosis list indicated diagnoses that included, but were not limited to, Encephalopathy, Pressure Ulcer of Right Hip-Stage 4 (four), Malnutrition, Type 1 (one) Diabetes Mellitus, Hypertension, Atrial Fibrillation, Alzheimer's Disease, Insomnia, and Depressive Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/31/24, assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of the clinical record indicated Resident #4 was transferred to the hospital on 9/13/24. On 2/26/25 at 10:12 AM, surveyor interviewed other staff #4 (OS#4) and she stated she could not find evidence of the ombudsman being notified of Resident #4's transfer/discharge on [DATE]. This concern was discussed at the pre-exit meeting on 2/26/25 at 1:44 PM with the administrator, director of nursing, regional director of clinical services, and assistant director of nursing. Surveyor requested and received a facility policy, titled, Notice of Transfer/Discharge with an effective date of 1/6/20, that read in part, .7. Provide designated copies of the completed .Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman .8. Scan a copy of the Notice of Transfer/Discharge into the patient's medical record .9. Once the document has been scanned .complete a Social Work and Discharge Planning Progress Note confirming the following .b. Date the notice was sent to the Ombudsman and method by which it was sent . No further information regarding this concern was presented to the survey team prior to the exit on 2/26/25.

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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. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow the medical provider's orders for 1 of 10 sampled residents (Resident #10). The findings included: For Resident #10, the facility staff administered Vitamin D3 10 mcg instead of the provider ordered Vitamin D 50 mcg. Resident #10's diagnosis list indicated diagnoses, which included, but not limited to Osteoarthritis of Knees and Right Shoulder, Congestive Heart Failure, and Moderate Protein-Calorie Malnutrition. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/28/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 2/26/25 at 8:33 AM, surveyor observed Licensed Practical Nurse (LPN) #2 prepare and administer Resident #10's medications. The administered medications included a Vitamin D3 10 mcg tablet. A review of Resident #10's medical provider orders revealed no order for Vitamin D3; however, the resident did have an order for Vitamin D 50 mcg to be administered at 9:00 am daily. Resident #10 did not receive Vitamin D during the medication administration observation. On 2/26/25 at 10:42 AM, surveyor spoke with LPN #2 regarding the Vitamin D3 and Vitamin D. LPN #2 looked in the medication cart and verified the cart contained a house stock bottle of Vitamin D3 but did not include Vitamin D for administration. During the six-minute medication administration observation for Resident #10, LPN #2 was interrupted on two separate occasions with medication deliveries from another staff member, one delivery included controlled medications and narcotic count records. Surveyor requested and received the facility policy titled General Guidelines for Medication Administration with a revision date of 8/2020 which read in part .4. At a minimum, the 5 Rights - right resident, right drug, right dose, right route, and right time - should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away .II. Administration .6. Medications are administered without unnecessary interruptions . On 2/26/25 at 1:45 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Regional Nurse Consultant and discussed the concern of Resident #10 receiving Vitamin D3 instead of Vitamin D. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/26/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, the facility staff failed to maintain an infection prevention and control program to provide a safe and sanitary environment and help prevent the development and transmission of infections for 1 of 10 residents (Resident #10). The findings included: For Resident #10, the nurse dropped an oral medication tablet on top of the medication cart and then administered the medication to the resident. On 2/26/25 at 8:37 AM during a medication pass and pour observation, surveyor observed Licensed Practical Nurse (LPN) #2 remove a Finasteride 5 mg tablet from a blister pack and the tablet inadvertently landed directly on top of the medication cart. LPN #2 donned a glove and picked up the tablet from the medication cart and placed it in the medication cup along with the resident's other medications. LPN #2 then administered the medications, including the Finasteride to Resident #10. On 2/26/25 at 1:45 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff administering an oral medication that had been in contact with the top of the medication cart. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/26/25.