| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366104 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Salem North Healthcare Center | 250 Continental Drive<br>Salem, OH 44460 |

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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567<br><br>Based on medical record review, staff interview, review of online medication resources, and review of facility policy, the facility failed to ensure residents did not receive unnecessary or duplicate medications. This affected one (Resident #67) of three residents reviewed for medication administration. The facility census was 66.<br><br>Findings include:<br><br>Review of the medical record for Resident #67 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included polyneuropathy, cellulitis of the lower limb, type two diabetes mellitus, lymphedema, weakness, adult failure to thrive, atrial fibrillation, oropharyngeal dysphagia, overactive bladder, Alzheimer's Disease, and vascular dementia.<br><br>Review of the admission Minimum Data Set (MDS) assessment for Resident #67 dated 07/30/24 revealed the resident had severe cognitive impairment and was dependent on staff for bathing, dressing, toileting hygiene, and personal hygiene.<br><br>Review of the physician's orders for Resident #67 revealed the following medication orders dated 08/15/24:<br><br>Aricept five milligrams (mg) for two weeks through 08/29/24) then increase to Aricept 10 mg daily for dementia (beginning 08/30/24). The Aricept order further specified once Resident #67 was on Namenda extended release (XR) 28mg and Aricept 10mg, he could begin taking his home medication, Namzaric 28-10mg (which contained Namenda XR 28mg and Aricept 10mg).<br><br>Namenda XR 7mg by mouth daily for two days (08/16/24 and 08/17/24), Namenda XR 14mg by mouth daily for dementia until 08/20/24, Namenda XR 21mg daily until 08/23/24, then Namenda XR 28mg by mouth daily for dementia. The order further specified once Resident #67 was on Namenda extended release (XR) 28mg and Aricept 10mg, he could begin taking Namzaric 28-10mg from his home medication supply.<br><br>Namzaric 28-10 mg (Namenda-Aricept), one capsule by mouth one time a day for dementia. The order further specified that Resident #67's wife was to supply the Namzaric, and Aricept and Namenda were to be discontinued at that time.<br><br>(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 |
|---|---|---|

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medication Administration Record (MAR) for Resident #67 dated August 2024 revealed the resident reached the desired dose of Namenda XR 28mg on 08/24/24 and received a daily dose of Namenda XR 28mg from 08/24/24 through 08/31/24. Further review of the August 2024 MAR revealed Resident #67 received a dose of Aricept 10mg on 08/30/24 and 08/31/24 and started receiving Namzaric 28-10mg on 08/31/24.<br><br>Review of the MAR for Resident #67 dated revealed documentation Resident #67 was administered Aricept 10mg, Namenda XR 28 mg, and Namzaric ER ,d+[DATE]mg (Namenda-Aricept) on 09/02/24, 09/03/24, 09/04/24, and 09/06/24.<br><br>Interviews on 12/12/24 with Licensed Practical Nurse (LPN) #335 at 9:24 A.M., with LPN #337 at 12:00 P.M., with LPN #323 at 12:10 P.M. confirmed the MAR documentation indicated Aricept 10mg, Namenda XR 28mg, and Namzaric ER ,d+[DATE]mg were marked as administered to Resident #67 on 08/31/24, 09/02/24, 09/03/24, 09/04/24, and 09/06/24.<br><br>Interview on 12/12/24 at 12:47 P.M. with the Director of Nursing (DON) confirmed the medication orders dated 08/15/24 indicated once Resident #67 was on the desired dose of Aricpet (10mg) amd Namenda XR (28mg), he was allowed to begin taking his Namzaric 28-10, brought in from his home, but the Aricept and the Namenda were supposed to be discontinued once he started taking the Namzaric 28-10mg daily. The DON further confirmed the August 2024 MAR contained documentation Resident #67 was given Aricept 10mg, Namenda XR 28mg, and Namzaric 28-10mg on 08/31/24 and the September 2024 MAR showed Resident #67 was given Aricept 10mg, Namenda XR 28mg, and Namzaric 28-10mg on 09/02/24, 09/03/24, 09/04/24, and 09/06/24.<br><br>Review of the on-line manufacturer patient Information sheet for Namzaric at https://www.rxabbvie.com/pdf/namzaric_pi.pdf#page=36 revealed the active ingredients in Namzaric were memantine HCl (Namenda) and donepezil HCl (Aricept) and that Namzaric should not be taken with any other medications that contained any of the ingredients in Namzaric.<br><br>Review of the facility policy titled Medication Administration revealed medications were to be administered only as prescribed by the ordering provider and should follow acceptable standards of nursing practice.<br><br>This deficiency represents noncompliance investigated under Complaint Number OH00159860. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>48567<br><br>Based on resident interview, observation, staff interview, record review, and review of the facility policy, the facility failed to ensure foods were served at a palatable temperature. This had the potential to affect 64 of the 66 residents (excluding Residents #16 and #65) who received meals prepared and served by the facility kitchen. The facility census was 66<br><br>Findings include:<br><br>Interview on 12/10/24 at 12:18 P.M. with Resident #38 confirmed foods were not served at the right temperatures<br><br>Interview on 12/10/24 at 4:00 P.M. with Resident #19 confirmed food and drinks served in the facility did not always keep the desired temperatures by the time the tray got to her.<br><br>Observation of tray line on 12/11/24 at 12:35 P.M. revealed the final meal trays were plated and placed on the meal cart for the main dining hall next to the kitchen. Surveyor requested a test tray as the last lunch tray was plated. The food cart was taken from the kitchen to the dining room at 12:49 P.M. Staff delivered meals and set-up for residents eating in the dining hall from 12:49 P.M. to 1:09 P.M.<br><br>Observation on 12/11/24 at 1:10 P.M. revealed Dietary Manager (DM) #384 removed the test tray from the meal cart and took food temperatures. The meatloaf was 121 degrees Fahrenheit (F), the peas were 112.1 degrees F, the au gratin potatoes were 122.9 degrees F, and the cranberry juice was 49 degrees F. The meatloaf tasted slightly warm, the peas were barely tepid, the first bite of potatoes from the bottom center of the scoop was tepid, and the bite of potatoes from the top was cold to taste. Though the juice cup remained cold to touch, the cranberry juice was not cold and not warm but was cooler than room temperature. There was no thermal pellet under the plate of the test tray.<br><br>Interview on 12/11/24 at 1:15 P.M. with DM #384 confirmed she would like to see the meat temperature maintained at 130 degrees F or higher, but a minimum of 129 degrees F, by the time it reached the residents. DM #384 further confirmed the kitchen ran out of thermal pellets prior to plating the test tray and not all residents received food that was held on the meal cart on a tray which contained a thermal pellet to prevent heat loss prior to serving.<br><br>Interview on 12/11/24 at 4:50 P.M. with Resident #57 confirmed hot foods got served cold at times. Further interview confirmed she participated in resident council and food committee meetings and food temperatures had been a common concern she felt had not been addressed.<br><br>Interview on 12/12/24 at 5:00 P.M. with Resident #37 confirmed she felt meals in the facility were always served cold.<br><br>Interview on 12/12/24 at 9:55 A.M. with DM #384 confirmed the facility was short at least 18 thermal pellets. She had informed the previous Administrator and was told to hold off on ordering more at that time. DM #384 also confirmed that the new Administrator was made aware of the concern of the shortage of thermal pellets on 12/11/24 and she ordered two dozen more for the facility on 12/11/24.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the food committee meeting minutes dated 09/20/24 revealed residents reported hot foods were being served cold. Review of the meeting minutes dated 10/18/24 and 11/15/24 revealed residents who participated in food committee meetings continued to report hot foods were served cold.<br><br>Review of the facility policy titled Dietary Operations-Time and Temperature Control and Recording undated revealed food holding included time spent for transport and delivery of food and the Food and Drug Administration (FDA) required hot foods to be maintained at 135 degrees F or higher and all cold foods to be maintained at 41 degrees F. The policy further revealed food was to be properly covered and any holding units, which included thermal pellets, insulated carts, and holding cabinets were to be preheated and maintained in good repair. The policy also stated it was imperative to limit the time between tray preparation and meal delivery to avoid a negative impact on palatability, temperature and overall satisfaction with the meal.<br><br>This deficiency represents noncompliance investigated under Complaint Number OH00159860. |